Supreme Court, U.S.
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In The

Supreme Court of the United States

DONNA SCHARFF,

Petitioner,

v.

RAYTHEON COMPANY SHORT TERM DISABILITY PLAN; RAYTHEON COMPANY LONG TERM DISABILITY PLAN,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I.

Whether the Ninth Circuit applied an overly restrictive standard for the incorporation of federal common law in a case arising under 29 U.S.C. § 1132(a)(1)(B) of the Employee Retirement Income Security Act of 1974 ("ERISA"), which failed to account for ERISA's broad preemption and lack of substantive protection for employees, and widened a split in the circuits.

II.

Whether the Ninth Circuit erred in refusing to incorporate a California regulation requiring notice of limitations periods through its mis-application of the standard for creation of federal common law, instead announcing a rule of constructive notice of the contents of Summary Plan Descriptions which creates a conflict in the circuits.

PARTIES TO THE PROCEEDING

Pursuant to Rule 14(1)(b), all the parties appearing here and before the United States Court of Appeals for the Ninth Circuit are contained in the caption.

TABLE OF CONTENTS

	Page
OPINIONS BELOW	1
JURISDICTION	1
STATUTES AND REGULATIONS INVOLVED	1
STATEMENT OF THE CASE	2
District Court Jurisdiction	2
Statement of Facts	2
Lower Court Proceedings	4
The District Court Opinion	4
The Ninth Circuit Decision	5
REASONS FOR GRANTING THE PETITION	7
I. Summary of Argument	7
II. The Ninth Circuit Applied an Inappropriate Standard for Incorporation of State Law into Federal Common Law, Which Conflicts with ERISA's Goals and Widened a Split in the Circuits	11
A. When Congress Preempted All State Laws Regulating Employee Benefit Plans, It Intended the Federal Courts to Devise a Body of Federal Common Law to Replace Them	11
1. ERISA Preempted State Laws Regulating Employee Benefit Plans, Replacing Them with Only Limited Procedural and No Substantive Protections	11

TABLE OF CONTENTS – Continued

Page

2. Congress Intended that the Federal Courts Would Replace State Regulation of Employee Benefit Plans Through Creation of Federal Common Law 16

B. The Ninth Circuit's Restrictive View of its Power to Incorporate Federal Law Is Contrary to the Statutory Scheme and this Court's Prior Holdings 21

C. The Ninth Circuit's Announced Standard for Creation of Federal Common Law Widens an Existing Split in the Circuits 27

III. The Ninth Circuit Erred in Refusing to Incorporate the California Notice Requirement, Announcing a Blanket Non-Disclosure Rule Creating a Split Within the Circuits 30

A. The Ninth Circuit's Blanket Non-Disclosure Rule Was in Error and Creates a Split in the Circuits 30

B. The Ninth Circuit Erred in Failing to Incorporate the California Notice Provision 35

CONCLUSION 39

TABLE OF CONTENTS – Continued

Page

APPENDIX

September 9, 2009 Opinion of the United States Court of Appeals for the Ninth Circuit.....App. 1

June 22, 2007 Judgment and Order of the District Court.....App. 29

January 15, 2010 Order of the United States Court of Appeals for the Ninth Circuit .....App. 50

Pertinent Excerpt of Reporters Transcript of Proceedings in the District Court, June 11, 2007 .....App. 51

29 U.S.C. § 1022 .....App. 54

10 California Code of Regulations § 2965.4.....App. 56

TABLE OF AUTHORITIES

Page

FEDERAL CASES

Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981) 11

Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980) 19

Anweiler v. American Elec. Power Service Corp., 3 F.3d 986 (7th Cir. 1993) 34

Barnes v. Independent Auto. Dealers Ass'n of California Health and Welfare Benefit Plan, 64 F.3d 1389 (9th Cir. 1995) 19

Barnes v. Lacy, 927 F.2d 539 (11th Cir. 1991) 31

Beddall v. State Street Bank and Trust Co., 137 F.3d 12 (1st Cir. 1998) 34

Blankenship v. Liberty Life Assur. Co. of Boston, 486 F.3d 620 (9th Cir. 2007) 20

Brown v. Aventis Pharmaceuticals, Inc., 341 F.3d 822 (8th Cir. 2003) 32

Burke v. PriceWaterHouseCoopers LLP Long Term Disability Plan, 572 F.3d 76 (2nd Cir. 2009) 36

Castello v. Gamache, 593 F.2d 358 (8th Cir. 1979) (per curiam) 31, 32

Central States, Southeast and Southwest Areas Pension Fund v. Central Transport, Inc., 472 U.S. 559 (1985) 25

TABLE OF AUTHORITIES – Continued

Page

Clark v. NBD Bank, N.A., 3 Fed.Appx. 500 (6th Cir. 2001) (per curiam) (unpublished table decision) 31

Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73 (1995) 13, 15

Eddy v. Colonial Life Ins. Co. of America, 919 F.2d 747 (D.C. Cir. 1990) 33

Equitable Life Assur. Soc. of U.S. v. Crysler, 66 F.3d 944 (8th Cir. 1995) 13

Estate of Shockley v. Alyeska Pipeline Service Co., 130 F.3d 403 (9th Cir. 1997) 5

Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101 (1989) 12, 19, 22

Franchise Tax Bd. of State of Cal. v. Construction Laborers Vacation Trust for Southern California, 463 U.S. 1 (1983) 16, 24

Holland v. Burlington Industries, Inc., 772 F.2d 1140 (4th Cir. 1985), *summarily aff'd*, 477 U.S. 901 (1986) 11

Hooven v. Exxon Mobil Corp., 465 F.3d 566 (3d Cir. 2006) 7, 9, 24

Horton v. Reliance Standard Life Ins. Co., 141 F.3d 1038 (11th Cir. 1998) 23, 38

Hummell v. S. E. Rykoff & Co., 634 F.2d 446 (9th Cir. 1980) 26

Inter-Modal Rail Employees Ass'n v. Atchison, Topeka and Santa Fe Ry. Co., 520 U.S. 510 (1997) 15

TABLE OF AUTHORITIES – Continued

Page

Jamail, Inc. v. Carpenters Dist. Council of Houston Pension & Welfare Trusts, 954 F.2d 299 (5th Cir. 1992) 18

Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482 (7th Cir. 1996) 12

Kearney v. Standard Ins. Co., 175 F.3d 1084 (9th Cir. 1999) 19

Kellogg v. Metropolitan Life Ins. Co., 549 F.3d 818 (10th Cir. 2008) 20

Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003) 15

Krohn v. Huron Memorial Hosp., 173 F.3d 542 (6th Cir. 1999) 33, 34

Kwatcher v. Massachusetts Service Employees Pension Fund, 879 F.2d 957 (1st Cir. 1989) 23

Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134 (1985) 21

Mauser v. Raytheon Co. Pension Plan for Salaried Employees, 239 F.3d 51 (1st Cir. 2001) 28

Mello v. Sara Lee Corp., 431 F.3d 440 (5th Cir. 2005) 18

Menhorn v. Firestone Tire & Rubber Co., 738 F.2d 1496 (9th Cir. 1984) 18

Mertens v. Hewitt Associates, 508 U.S. 248 (1993) 23

Metropolitan Life Ins. Co. v. Glenn, 128 S.Ct. 2343 (2008) 34

TABLE OF AUTHORITIES – Continued

Page

Metropolitan Life Ins. Co. v. Johnson, 297 F.3d 558 (7th Cir. 2002) 20

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) 15

Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58 (1987) 12, 18

Minnesota Laborers Health and Welfare Fund v. Scanlan, 360 F.3d 925 (8th Cir. 2004) 20

Nachwalter v. Christie, 805 F.2d 956 (11th Cir. 1986) 35

Northlake Regional Medical Center v. Waffle House System Employee Benefit Plan, 160 F.3d 1301 (11th Cir. 1998) 27, 36

Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan, 195 F.3d 975 (7th Cir. 1999) 19

Phoenix Mut. Life Ins. Co. v. Adams, 30 F.3d 554 (4th Cir. 1994) 29

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) 11, 12, 21, 23

Price v. Provident Life and Acc. Ins. Co., 2 F.3d 986 (9th Cir. 1993) 19, 36

Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002) 21

Saltarelli v. Bob Baker Group Medical Trust, 35 F.3d 382 (9th Cir. 1994) 20

TABLE OF AUTHORITIES – Continued

Page

Schikore v. BankAmerica Supplemental Retirement Plan, 269 F.3d 956 (9th Cir. 2001).....20

Schultz v. Metro. Life Ins. Co., 872 F.2d 676 (5th Cir. 1989).....31, 32

Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983).....13, 27

Shipley v. Arkansas Blue Cross and Blue Shield, 333 F.3d 898 (8th Cir. 2003).....28

Solien v. Raytheon Long Term Disability Plan #590, 2008 WL 2323915 (D.Ariz. 2008).....3, 6, 35

Stamp v. Metropolitan Life Ins. Co., 531 F.3d 84 (1st Cir. 2008).....20

Textile Workers Union of America v. Lincoln Mills of Ala., 353 U.S. 448 (1957).....17, 38

Trustmark Life Ins. Co. v. University of Chicago Hospitals, 207 F.3d 876 (7th Cir. 2000).....38

United States v. Little Lake Misere Land Co., Inc., 412 U.S. 580 (1973).....9, 24

UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358 (1999).....30

Van Orman v. American Ins. Co., 680 F.2d 301 (3rd Cir. 1982).....29, 30

Varity Corp. v. Howe, 516 U.S. 489 (1996)....20, 21, 25, 35

Warner v. Ford Motor Co., 46 F.3d 531 (6th Cir. 1995) (en banc).....12

TABLE OF AUTHORITIES – Continued

Page

Welch v. Metropolitan Life Ins. Co., 480 F.3d 942 (9th Cir. 2007) 26

Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Ins. Program, 222 F.3d 643 (9th Cir. 2000) 19

White v. Sun Life Assur. Co. of Canada, 488 F.3d 240 (4th Cir. 2007) 27

Whitworth Bros. Storage Co. v. Central States Southeast & Southwest Areas Pension Fund, 982 F.2d 1006 (6th Cir. 1993) 29, 30

Winters v. Costco Wholesale Corp., 49 F.3d 550 (9th Cir. 1995) 5

FEDERAL RULES

Fed. R. Civ. Proc. 12(b)(6) 4

FEDERAL STATUTES

16 U.S.C. § 715 24

28 U.S.C. § 1254(1) 1

28 U.S.C. § 1331 2

28 U.S.C. § 1345 24

29 U.S.C. § 185 ..... 8, 16, 17, 18

29 U.S.C. § 1002(2) 13

29 U.S.C. § 1002(2)(A) 13

29 U.S.C. § 1021(b) 14

TABLE OF AUTHORITIES – Continued

Page

29 U.S.C. § 1022 .....1, 14
29 U.S.C. § 1022(b) 26
29 U.S.C. § 1023 14
29 U.S.C. § 1027 14
29 U.S.C. § 1059 14
29 U.S.C. § 1102 15
29 U.S.C. § 1104 14
29 U.S.C. § 1104(a) 25
29 U.S.C. § 1106 14
29 U.S.C. § 1132 .....14, 26
29 U.S.C. § 1132(a) 12, 14, 21
29 U.S.C. § 1132(a)(1)(B) 14, 21
29 U.S.C. § 1132(g)(1) 26
29 U.S.C. § 1144 16
29 U.S.C. § 1144(a) 11
29 U.S.C. § 1144(b)(2)(A) 15

STATE CASES

Wells v. Wilbur B. Driver Co., 121 N.J.Super. 185, 296 A.2d 352 (1972) 32

STATE REGULATIONS

Cal. Code Regs. tit. 10, s 2694.4(a) 5
Cal. Code Regs. tit. 10, s 2695.4 1

OPINIONS BELOW

The opinion of the Court of Appeals for the Ninth Circuit is reported at 581 F.3d 899, and is reprinted in the Appendix to the Petition ("Pet. App.") at 1. The District Court's opinion is not reported, but is available at 2007 WL 2947566, and is reprinted at Pet. App. 29.

JURISDICTION

The Court of Appeals for the Ninth Circuit issued its opinion on September 9, 2009. The Court of Appeals entered its order denying rehearing and rehearing en banc on January 25, 2010. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

This case references a provision of ERISA, specifically 29 U.S.C. § 1022, and a California Regulation, Cal. Code Regs. tit. 10, s 2695.4. The pertinent provisions are reproduced at Pet. App. 54.

STATEMENT OF THE CASE

District Court Jurisdiction

The court of first instance, the United States District Court for the Central District of California, had jurisdiction of this matter pursuant to 28 U.S.C. § 1331.

Statement of Facts

Due to her employment with Raytheon Company ("Raytheon"), Donna Scharff was covered under Raytheon's short term disability ("STD") plan, and its long term disability ("LTD") plan. Pet. App. 30. The STD plan was funded through employee contributions, and was administered by Metropolitan Life Insurance Company ("Met Life"). Pet. App. 30. Unless STD benefits are paid an employee has no right to LTD benefits. Pet. App. 34.

Raytheon provided its employees with a Summary Plan Description ("SPD"), divided into chapters addressing the various benefits available, with a final chapter labeled "Administrative." Pet. App. 3. The thirteen page chapter dealing with disability benefits has a section with a bold-face heading of "Claims Appeal Procedure." Under this heading, the following paragraph appears:

> The procedure to be followed to appeal a denied claim is explained in the Administrative section. It is important to note that under the applicable [Plan] documents, any action at law or in equity must be commenced

> within one year of the denial of the appeal from an initial claim denial, regardless of any state or federal statutes establishing provisions relating to limitations of actions.

Pet. App. 4, 31.

The one year limitation to sue was not referenced anywhere else in the SPD, and is not easy to locate. In *Solien v. Raytheon Long Term Disability Plan #590,* 2008 WL 2323915, *7 (D.Ariz. 2008), the District Judge stated that the SPD's table and document headings gave little clue to where the limitation was located; he attempted to find it but could not without a page citation.

On April 15, 2005 Scharff was unable to continue working and made a claim with Met Life for STD benefits. On July 18, 2005, Met Life denied the claim, contending that Scharff's condition was not severe enough to disable her. Scharff provided additional information from her physician attesting to the severity of her condition, and on September 16, 2005 Met Life denied Scharff's claim yet again. Pet. App. 32.

Scharff appealed on October 28, 2005. In a letter dated January 12, 2006, Met Life upheld the denial. The letter informed Plaintiff that if "you wish to pursue the matter further you should consult the information provided concerning your rights, as set forth in the Summary Plan Description." The letter also stated that Scharff had no further appeals available, but that she had a "right to bring a civil

action under Section 502(a) of [ERISA]." Pet. App. 5. Neither this January 12th letter, nor any of the previous denial letters, gave Scharff any notice of the one year limitations period. Pet. App. 5.

On May 26, 2006 Scharff's daughter, Jessica Leighty, filed a complaint with the California Department of Insurance on Scharff's behalf. Met Life responded with a letter it had previously written to Leighty, notifying her that the Plan was self-funded and not governed by California insurance regulations. Met Life's letter stated that Scharff had the right to bring a civil action, but -- again – failed to provide any notice of the shortened limitations period. Pet. App. 33-34.

On February 1, 2007, twenty days after the limitations period expired, Scharff filed suit. The Raytheon Plan responded with a Fed. R. Civ. Proc. 12(b)(6) motion to dismiss, contending that the lawsuit was untimely. The Plan's motion was granted by the district court, a decision upheld by a panel of the Ninth Circuit. Pet. App. 5-6, 20.

Lower Court Proceedings

The District Court Opinion

The district court ruled that a contractually shortened limitations period in an ERISA plan would be upheld if it was "reasonable." The court held that the one year period here met this standard.

Scharff contended that the court should incorporate a California Regulation, Cal. Code Regs. tit. 10, s 2694.4(a), which mandates that "[e]very insurer shall disclose to a first party claimant or beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant." The district court stated that this insurance regulation did not apply because the Raytheon Plan was self-funded. It also rejected Scharff's contention that this provision should be incorporated into federal common law. Pet. App. 42-45.

Scharff also argued that the one year limitation violated the "reasonable expectations doctrine," which enforces a claimant's objectively reasonable expectations of coverage, as it was not sufficiently "clear, plain or conspicuous." The district court held that this doctrine only applied to insured plans. As such, the district court never undertook to determine whether the limitation was clear and capable of ready understanding.

The Ninth Circuit Decision

With respect to the "reasonable expectations" argument, the Ninth Circuit recognized this state law doctrine had been incorporated into federal common law. It noted an intra-circuit conflict, with *Winters v. Costco Wholesale Corp.*, 49 F.3d 550 (9th Cir. 1995) applying the doctrine (at least in dicta) to a self-funded plan, where *Estate of Shockley v. Alyeska*

Pipeline Service Co., 130 F.3d 403, 407 (9th Cir. 1997) limited the doctrine to only insured plans. The two judge panel majority assumed without deciding that the doctrine applied, and stated, without analysis, that "the SPD here met plan participants' reasonable expectations" Pet. App. 14.[1]

With respect to whether the California law requiring separate notification of limitations should be incorporated into federal law, the panel held – incorrectly – that Federal courts had only limited power to incorporate state law:

> As the Third Circuit has noted, "federal courts may not lightly create additional rights under the rubric of federal common law; we may exercise our common law authority to fashion new ERISA causes of action only where we deem it necessary to fill

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[1] In dissent, Judge Pregerson stated that he did not "think that an average plan participant could successfully navigate through Raytheon's labyrinthine Summary Plan Description." Pet. App. 20. Judge Pregerson noted that the limitation was not located in a place where the participant would be expected to find it, and that notification of the participant's right to bring a lawsuit was in a different section than the statement limiting that right.

Judge Pregerson also pointed out that in *Solien v. Raytheon Long Term Disability Plan*, No. CV 07-456, 2008 WL 2323915 at *7 (D.Ariz. 2008) a district judge reviewing the same plan, "noted his own difficulty in locating the one-year limitation." Pet. App. 23, n. 2. Judge Pregerson concluded that "[i]f one thing is clear, it's that this plan is confusing." Pet. App. 27.

> in interstitially or otherwise effectuate the statutory pattern enacted in the large by Congress." *Hooven v. Exxon Mobil Corp.*, 465 F.3d 566, 573 n. 5 (3d Cir. 2006) (internal quotation marks omitted).

Pet. App. 18. The panel held that "ERISA and its implementing regulations contain broad and detailed disclosure rules to protect plan beneficiaries," and that it saw "no need to supplement the comprehensive scheme already in place for regulating plan administrators' disclosures to participants." Pet. App. 18. It also stated that the California notice rule would conflict with the law of four other circuits that employees have constructive notice of the SPD's contents. Pet. App. 19.

REASONS FOR GRANTING THE PETITION

I. Summary of Argument

This case involves a plan participant, Donna Scharff, who lost her opportunity to challenge an unwarranted denial of ERISA disability benefits because of a one year limitations period contained in the SPD. Normally, a four year limitations period applies, and California insurance law would have required disclosure of the shorter period at the time of the denial. Due to the fact that this plan was self-funded, the California insurance regulation does not apply, and the Ninth Circuit refused to incorporate

and apply the California rule as part of federal common law.

The Ninth Circuit's decision that courts "may not lightly create" federal common law except where "necessary" to fill explicit gaps in the statutory structure is a fundamental misunderstanding of the federal courts' role in implementing ERISA which widens a split already existing in the circuits. ERISA's primary goal was protection of employee rights, yet it preempted all state regulations of employee benefit plans, and – especially with the self-funded welfare plan at issue here – created no substantive and almost no procedural protections to supplant them. The congressional purpose was that the federal courts would – as with Section 301 of the Labor Management Relations Act – replace the displaced state law with common law effectuating ERISA's twin goals of (1) protecting employee rights, and (2) avoiding excessive burden on plan administration.

Given this lack of substantive statutory regulation and the sparsity of procedural protections, federal courts have taken up the task of creating or incorporating common law to answer questions not addressed in ERISA's text. The courts have created common law governing a wide variety of issues, such as standards of review, administrative procedures, conflicted fiduciaries, limited admissibility of evidence, statutes of limitations and so on.

In reaching its result, the Ninth Circuit erroneously determined that it had only limited power to

create or incorporate federal common law. This is not only the wrong standard, but was obtained from an inappropriate body of law.

Specifically, the Ninth Circuit cited to a Third Circuit case,[2] which in turn borrowed its standard from *Little Lake Misere*,[3] a decision of this Court. However, *Little Lake Misere* was not an ERISA case, and was brought pursuant to a statute that "fail[ed] to specify whether or to what extent it contemplates displacement of state law." *Little Lake Misere*, 412 U.S. at 593, n. 10. As such, it was a poor choice to supply a standard here, with ERISA's sweeping preemption clause and exclusive enforcement mechanism which plainly evidenced congressional intent that federal law would occupy the field.

In applying this Third Circuit standard, the Ninth Circuit widened an existing split in the circuits. Numerous other circuits apply the more appropriate standard argued for here, that courts may freely fashion federal common law to address a question not directly answered by the statutory scheme, so long as the law furthers ERISA's stated goals.

Moreover, in rejecting the California regulation, the Ninth Circuit followed what it claimed was a

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[2] *Hooven v. Exxon Mobil Corp.*, 465 F.3d 566 (3rd Cir. 2006).

[3] *United States v. Little Lake Misere Land Co., Inc.*, 412 U.S. 580 (1973).

rule from four other circuits that disclosure in the SPD provides constructive notice to participants as a matter of law. In doing so the Ninth Circuit misstated the law in those circuits. It also creates a conflict with other circuits which recognize an ERISA fiduciary's obligation to provide information concerning a substantial risk to a participant's right to benefits, even if already contained in the SPD.

Under the proper standard, the California rule requiring separate notification of a shortened limitations period is an obvious candidate for incorporation. It is not a question answered by the statutory language, which says nothing about whether an ERISA benefits action even has a limitations period, much less what it should be and whether it could be modified by contract. Moreover, the California rule protects participants from unusually brief limitations periods, in one case as short as 90 days, which can deprive them of their right to challenge incorrect and arbitrary benefit denials.

The burden on plan administration from adoption of this rule would be minimal. It has been applied to insured plans with no apparent disruption. It would not hinder plan sponsors from including shortened limitations purposes for any legitimate purpose. It only requires that shortened limitations periods be separately disclosed.

II. The Ninth Circuit Applied an Inappropriate Standard for Incorporation of State Law into Federal Common Law, Which Conflicts with ERISA's Goals and Widened a Split in the Circuits

A. When Congress Preempted All State Laws Regulating Employee Benefit Plans, It Intended the Federal Courts to Devise a Body of Federal Common Law to Replace Them

1. ERISA Preempted State Laws Regulating Employee Benefit Plans, Replacing Them with Only Limited Procedural and No Substantive Protections

When Congress enacted ERISA it incorporated "deliberately expansive" preemption provisions designed to make the regulation of both self-funded and insured employee benefit plans "exclusively a federal concern," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)).

To ensure that state law would not intrude on plan administration, Congress armed ERISA with a preemption clause of "unparalleled breadth" in 29 U.S.C. § 1144(a). *Holland v. Burlington Industries, Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), *summarily aff'd*, 477 U.S. 901 (1986). This clause states that ERISA "supersede[s] any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan." 29 U.S.C. § 1144(a) (emphasis added).

Moreover, Congress used the words "relate to" in their "broad common-sense meaning" of having "a connection with or reference to . . . a plan." *Pilot Life*, 481 U.S. at 47.

In addition to the preemption clause, Congress also added "six carefully integrated civil enforcement provisions" in 29 U.S.C. § 1132(a) which Congress intended would provide an "exclusive" federal remedy for claims regarding ERISA benefits claims or ERISA plan administration. *Pilot Life*, 481 U.S. at 54-6. Here, preemption is premised on the fact that "Congress intended federal law to occupy the regulated field of pension contract enforcement." *Warner v. Ford Motor Co.*, 46 F.3d 531, 535 (6th Cir. 1995) (en banc).

This second aspect of preemption "is so powerful that it converts 'a state law claim into an action arising under federal law,' even if the plaintiff does not want relief under ERISA." *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1490 (7th Cir. 1996) (quoting from *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65 (1987)). In short, the Congressional intent could not be clearer that the field of employee benefits would be entirely occupied by federal law.

The primary congressional purpose in enacting this statutory scheme which ousted all state law touching upon employee benefit plans was "to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989)

(citations and attributions omitted); *Also*, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983) ("ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans").

In spite of this ostensible purpose, when it swept away any and all state regulation protecting employee rights to employee benefit plans, Congress generally failed to replace them with protections of its own. While there is some minimal substantive content with respect to ERISA pension plans,[4] ERISA is entirely silent with respect to the substantive requirements of ERISA welfare plans.[5] "In many respects, Congress elected to regulate welfare benefit plans less rigorously." *Equitable Life Assur. Soc. of U.S. v. Crysler*, 66 F.3d 944, 948 (8th Cir. 1995). *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) ("Nor does ERISA establish any minimum participation, vesting, or funding requirements for welfare plans as it does for pension plans").

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[4] A "pension plan," as the name suggests, is one that provides an employee with either retirement income or deferred income. 29 U.S.C. § 1002(2)(A).

[5] A "welfare plan" provides participants and their beneficiaries with "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services." 29 U.S.C. § 1002(2).

ERISA does provide some procedural requirements, such as the reporting requirement to the Department of Labor (29 U.S.C. §§ 1021(b), 1023), disclosure of plan information to participants (29 U.S.C. § 1022), retention of records requirements (29 U.S.C. §§ 1027, 1059), setting a standard for fiduciary obligations in handling plan assets (29 U.S.C. § 1104) and prohibiting certain conflicts of interest. (29 U.S.C. § 1106). ERISA also contains requirements for notification and review of denied benefit claims (29 U.S.C. § 1132), as well as remedies for the violations of its terms or to adjudicate a participant's rights under the plan. (29 U.S.C. § 1132(a)).

However, these procedural provisions provide little detail and would clearly be insufficient without the supplementation of judge-created federal common law. For example ERISA contains a remedy for challenging a denial of benefits (29 U.S.C. § 1132(a)(1)(B)), but does not explain how these suits are to be conducted. It provides no detail on whether a jury trial is required, what evidence should be permitted, or the standard of review to be applied. Issues including conflicted fiduciaries, the period and the accrual date of the statutes of limitations, whether discovery should be permitted and whether exhaustion of remedies is required prior to bringing suit were left for the courts to decide.

Moreover, at least with respect to welfare benefit plans, ERISA provides no substantive protections for employees *at all*. ERISA provides no rules for what is required to be actually *in* the plan documents,

or what rights to benefits the employee or beneficiary may have against the plan. ERISA "does not regulate the substantive content of welfare-benefit plans." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985). "In interpreting § 402(b)(3) [29 U.S.C. § 1102 as codified, dealing with the requirement for plan amendment], we are mindful that ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995). Under the statutory language, the employee has only those rights that are written into the plan documents, and no more:

> Thus, unless an employer contractually cedes its freedom, it is generally free under ERISA, for any reason at any time, to adopt, modify, or terminate its welfare plan.

Inter-Modal Rail Employees Ass'n v. Atchison, Topeka and Santa Fe Ry. Co., 520 U.S. 510, 515 (1997) (citation and attribution omitted).

Insurance funded welfare plans are still regulated by state laws due to the impact of ERISA's "savings clause." 29 U.S.C. § 1144(b)(2)(A); *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341-42 (2003). However, with respect to self-funded welfare plans, Congress preempted state laws governing such plans in their entirety, while creating nothing to fill the resulting vacuum.

2. Congress Intended that the Federal Courts Would Replace State Regulation of Employee Benefit Plans Through Creation of Federal Common Law

The congressional intent in sweeping away state laws regulating employee benefit plans without replacing them with federal regulation was that the federal courts would use federal common law to flesh out the statutory scheme. One of ERISA's sponsors, Senator Javits, stated that creation of federal common law was required due to ERISA's expansive preemption provision:

> In addition, ERISA's legislative history indicates that, in light of the act's virtually unique preemption provision, see § 514, [29] U.S.C. § 1144, "a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits).

Franchise Tax Bd. of State of Cal. v. Construction Laborers Vacation Trust for Southern California, 463 U.S. 1, 25, n. 26 (1983).

Congressional reliance on the federal courts' rule making ability was based on its experience with Section 301 of the Labor Relations Management Act ("LMRA").[6] Like ERISA, Section 301 of the LMRA

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[6] As codified, 29 U.S.C. § 185.

federalized a significant area of the law – in that case employer/employee relations – with little if any substantive provisions. This Court was quick to recognize the federal court's obligation to create a body of federal common law to govern this area of the law over which it had been handed responsibility:

> The Labor Management Relations Act expressly furnishes some substantive law. It points out what the parties may or may not do in certain situations. Other problems will lie in the penumbra of express statutory mandates. Some will lack express statutory sanction but will be solved by looking at the policy of the legislation and fashioning a remedy that will effectuate that policy. The range of judicial inventiveness will be determined by the nature of the problem.

Textile Workers Union of America v. Lincoln Mills of Ala., 353 U.S. 448, 457 (1957).

With ERISA Congress intended federal courts to perform the same function as with Section 301 of the LMRA. One of ERISA's sponsors expressly stated that federal courts would treat suits arising under ERISA the same as suits arising under Section 301 of the LMRA:

> Senator Williams, a sponsor of ERISA, emphasized that the civil enforcement section would enable participants and beneficiaries to bring suit to recover benefits denied contrary to the terms of the plan and that

> when they did so "[i]t is intended that such actions will be regarded as arising under the laws of the United States, in similar fashion to those brought under section 301 of the Labor Management Relations Act." 120 Cong.Rec. 29933 (1974).

Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 66 (1987). Lower courts understood this directive to create laws governing the conduct of ERISA lawsuits:

> In the context of its adoption of a federal scheme to regulate employee benefit plans, Congress has expressed an identical intent [as with Section 301 of the LMRA]. The courts are directed to formulate a nationally uniform federal common law to supplement the explicit provisions and general policies set out in ERISA, referring to and guided by principles of state law when appropriate, but governed by the federal policies at issue.

Menhorn v. Firestone Tire & Rubber Co., 738 F.2d 1496, 1499-1500 (9th Cir. 1984). *Also*, *Mello v. Sara Lee Corp.*, 431 F.3d 440, 444 (5th Cir. 2005) ("In light of [ERISA's preemption provision], courts are to develop a federal common law of rights and obligations under ERISA-regulated plans"); *Jamail, Inc. v. Carpenters Dist. Council of Houston Pension & Welfare Trusts*, 954 F.2d 299, 303 (5th Cir. 1992) ("due to the broad preemption provisions, a body of federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans").

Given the broad scope of ERISA preemption coupled with the minimal regulation imposed by Congress, the federal courts have accepted the congressional mandate to create federal common law governing the conduct of ERISA plans and lawsuits brought pursuant to ERISA. Federal courts, including this Court, have imposed a discretionary standard of review for certain plan fiduciaries,[7] have required that participants exhaust their remedies under the plan prior to bringing a lawsuit,[8] have created rules regarding the length[9] and accrual[10] of the statute of limitations, and have created rules limiting both the admissibility of evidence[11] and availability of discovery.[12]

Courts have also, pursuant to their power to make federal common law, imported a number of state law doctrines, such as the "make whole doctrine,"[13] the

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[7] *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

[8] *Amato v. Bernard*, 618 F.2d 559 (9th Cir. 1980).

[9] *Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Ins. Program*, 222 F.3d 643 (9th Cir. 2000).

[10] *Price v. Provident Life and Acc. Ins. Co.*, 2 F.3d 986, 988 (9th Cir. 1993).

[11] *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1091 (9th Cir. 1999).

[12] *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975, 981 (7th Cir. 1999).

[13] *Barnes v. Independent Auto. Dealers Ass'n of California Health and Welfare Benefit Plan*, 64 F.3d 1389, 1395 (9th Cir. 1995).

"mailbox rule,"[14] the "reasonable expectations doctrine,"[15] the "substantial compliance doctrine,"[16] and "contra proferentem."[17] Courts have created federal common law for interpretation of ERISA plan documents[18] and for piercing the corporate veil in ERISA cases.[19] Federal common law has been used to decide whether an alcohol related car fatality was an "accident,"[20] and to interpret the scope of a fiduciary's duties.[21]

None of these courts expressed any hesitation with respect to the creation of common law, or expressed any limitation on their right to create this law other than the need to further the congressional goals.[22] The Ninth Circuit, in announcing this

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[14] *Schikore v. BankAmerica Supplemental Retirement Plan*, 269 F.3d 956, 961 (9th Cir. 2001).

[15] *Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382 (9th Cir. 1994).

[16] *Metropolitan Life Ins. Co. v. Johnson*, 297 F.3d 558, 567 (7th Cir. 2002).

[17] *Blankenship v. Liberty Life Assur. Co. of Boston*, 486 F.3d 620, 625 (9th Cir. 2007).

[18] *Kellogg v. Metropolitan Life Ins. Co.*, 549 F.3d 818, 830 (10th Cir. 2008).

[19] *Minnesota Laborers Health and Welfare Fund v. Scanlan*, 360 F.3d 925, 928 (8th Cir. 2004).

[20] *Stamp v. Metropolitan Life Ins. Co.*, 531 F.3d 84, 90 (1st Cir. 2008).

[21] *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

[22] One area where courts have been properly reluctant to expand on the Congressional scheme is with respect to the creation of additional remedies. This Court has consistently held

(Continued on following page)

restrictive view of the power of federal courts to create common law to regulate ERISA, is at odds with this extensive body of case law.

B. The Ninth Circuit's Restrictive View of its Power to Incorporate Federal Law Is Contrary to the Statutory Scheme and this Court's Prior Holdings

In failing to recognize its power and obligation to create federal common law where it furthered ERISA's goals, the Ninth Circuit applied an incorrect standard, borrowed from an inapt body of law. Its holdings that "federal courts may not lightly create

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that the civil enforcement provisions contained in 29 U.S.C. § 1132(a) contain an exclusive list of the remedies authorized by Congress. "The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). *Also*, *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985) ("The six carefully integrated civil enforcement provisions found in § 502(a) of the statute [as codified, 29 U.S.C. § 1132(a)] as finally enacted, however, provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly"); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 377 (2002) ("Congress intended a federal common law of rights and obligations to develop under ERISA, without embellishment by independent state remedies"). Of course, this limitation is not relevant here, as Scharff argued only for incorporation of federal common law in the context of a claim specifically permitted under ERISA. 29 U.S.C. § 1132(a)(1)(B).

additional rights under the rubric of federal common law," or that it may fashion federal common law only when "necessary to fill in interstitially or otherwise effectuate the statutory pattern enacted in the large by Congress" Pet. App. 18 (citation and attribution omitted) are wrong on numerous levels.

First, this reluctance to exercise the court's rule making ability when consistent with ERISA's provisions and goals appears nowhere in the dictates of this Court. To the contrary, *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989) commanded that "courts are to develop a federal common law of rights and obligations under ERISA-regulated plans." *Id.* at 101 (citations and attributions omitted). This Court empowered lower federal courts to create common law wherever a question cannot be resolved by reference to the statutory scheme, if the proposed rule furthers ERISA's competing purposes of "promot[ing] the interests of employees and their beneficiaries in employee benefit plans," and encouraging the growth of employee benefit plans. *Bruch*, 489 U.S. at 113-115.

As such, before creating or incorporating federal common law, courts should "take account of competing congressional purposes, such as Congress' desire to offer employees enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe,* 516 U.S. 489, 497 (1996). However, where a proposed rule

would "further ERISA's scheme and goals"[23] and is not expressly contradicted by the statutory language,[24] it should be readily adopted.[25]

Further, in stating that common law could only be used to fill specific gaps in the statutory scheme, the Ninth Circuit failed to recognize that ERISA swept away the protections of state law without enacting safeguards to replace them. This is not a matter of filling gaps; the employee in a self-funded welfare plan has limited procedural protections, and no substantive protections at all, other than what the federal courts may grant. "Given the 'expansive sweep' of ERISA preemption, *Pilot Life*, 481 U.S. at 47, 107 S.Ct. at 1553, Congress expected 'that a federal common law of rights and obligations under ERISA-regulated plans would develop.'" *Kwatcher v. Massachusetts Service Employees Pension Fund*, 879 F.2d 957, 966 (1st Cir. 1989) (*abrogated on other grounds*, *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1). The Ninth Circuit's

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[23] *Horton v. Reliance Standard Life Ins. Co.*, 141 F.3d 1038, 1041 (11th Cir. 1998)

[24] ("*E.g.*, *Mertens v. Hewitt Associates*, 508 U.S. 248, 261 (1993) vague notions of a statute's 'basic purpose' are nonetheless inadequate to overcome the words of its text regarding the specific issue under consideration.")

[25] Clarification in this area is especially needed given that the district court stated .that incorporation here was "the fair thing to do," and "almost even seems the right thing to do," but doubted its authority to act in this fashion. Pet. App. 53.

reluctance might have been appropriate were there a fully developed body of law in place; it is inappropriate in an area where federal common law is virtually the sole source of authority.

Moreover, given ERISA's expansive preemption of state law, the Ninth Circuit's understanding that it may "not lightly create additional rights under the rubric of federal common law" is not grounded in appropriate authority. The Ninth Circuit relied on *Hooven v. Exxon Mobil Corp.*, 465 F.3d 566, 573, n. 5 (3rd Cir. 2006) which, in turn, obtained the standard from this Court's decision in *United States v. Little Lake Misere Land Co., Inc.*, 412 U.S. 580, 592 (1973). But *Little Lake Misere* involved the Migratory Bird Conservation Act,[26] with Federal Question jurisdiction existing only because the United States was a plaintiff.[27] This was not an area where Congress had preempted all potential state laws which might govern the lawsuit. Rather, this Court recognized that "no provision of the Migratory Bird Conservation Act guides us to choose state or federal law in interpreting federal land acquisition agreements under the Act." *Little Lake Misere*, 412 U.S. at 593.

ERISA by contrast, contains a "virtually unique preemption provision" *Franchise Tax Bd.*, 463 U.S. at 25, n. 26, which mandates application of federal law. ERISA also contains virtually no substantive

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[26] 16 U.S.C. § 715 et seq.

[27] The basis of jurisdiction was 28 U.S.C. § 1345.

provisions which, in turn, justifies the Congressional mandate that the federal courts would freely create federal common law. As such, the Ninth Circuit erred in adopting this as the standard for creation of federal common law in the context of an ERISA benefits action.

In support of its holding, the Ninth Circuit noted that Congress had addressed that the applicable limitations period was one of the subjects required to be addressed in the SPD. However, its understanding that the federal courts can act only where Congress left a "gap" in ERISA's statutory scheme is wrong for numerous reasons. First, given the lack of detail in the areas Congress did choose to address, this does not eliminate the need for common law.

For example, while Congress created a "[p]rudent man standard of care," for ERISA fiduciaries in 29 U.S.C.A. § 1104(a), "Congress expected that the courts will interpret this prudent man rule (and the other fiduciary standards) bearing in mind the special nature and purpose of employee benefit plans, as they develop a federal common law of rights and obligations under ERISA-regulated plans." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (citations and attributions omitted). *Also*, *Central States, Southeast and Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570 (1985) ("rather than explicitly enumerating all of the powers and duties of trustees and other fiduciaries, Congress invoked the common law of trusts to define the general scope of their authority and responsibility").

Also, while Congress did state that "the court in its discretion may allow a reasonable attorney's fee and costs of action to either party" 29 U.S.C. § 1132(g)(1), the courts still needed to address the circumstances under which such an award was appropriate[28] as well as standards for determining the amount of attorney fees.[29] These areas, then, might not be "gaps" in ERISA's statutory scheme – as Congress did address them – however federal common law is still necessary to expand on and explain the statutory scheme.

Moreover, 29 U.S.C. § 1022(b) (which arguably requires limitations periods to be disclosed in the SPD) notwithstanding, the limitations period for ERISA claims was obviously one of the "gaps," in which Congress failed to legislate. ERISA says nothing about the proper limitations period for any of the causes of action it authorized in 29 U.S.C. § 1132. It does not provide for when the limitation periods accrue, or whether the limitation period and the time of accrual may be modified by contract.

As such, the issues on which the Ninth Circuit ruled that Ms. Scharff had lost her right to challenge the denial of her benefits, including the normal period

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[28] *Hummell v. S. E. Rykoff & Co.*, 634 F.2d 446, 453 (9th Cir. 1980) ("we agree with the Fifth and Tenth Circuits that district courts should have guidelines to apply in the exercise of their discretion under s 1132(g)").

[29] *Welch v. Metropolitan Life Ins. Co.*, 480 F.3d 942, 945 (9th Cir. 2007).

of limitations, whether it can be modified by contract, and the standard for whether the modification was reasonable, are *all* creatures of federal common law created from whole cloth by federal courts. It lacks logic that federal common law may be created to find the *90 day* limitation period in *Northlake Regional Medical Center v. Waffle House System Employee Benefit Plan*, 160 F.3d 1301, 1304 (11th Cir. 1998) is "reasonable," but not to incorporate a rule requiring disclosure of this absurdly short limitations period. This is especially true given that ERISA's primary goal and the central driving rationale behind creation of common law is the protection of "employees and their beneficiaries." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983).

C. The Ninth Circuit's Announced Standard for Creation of Federal Common Law Widens an Existing Split in the Circuits

The Ninth Circuit's decision not only applied the wrong standard for creation of federal common law, but widened existing splits in the circuits in two different respects. As noted above, the Ninth Circuit joined the Third in incorrectly holding that courts should hesitate to create Federal common law in

ERISA cases, and only where there are "gaps" in the statutory structure.[30]

Other circuits, consistent with this Court's prior holdings, mandate creation or incorporation of federal common law where the question at hand is not answered by ERISA's statutory language, so long as the proposed rule is consistent with and furthers ERISA's policies of protecting employees while not overly burdening plan administration. For example, in *Shipley v. Arkansas Blue Cross and Blue Shield*, 333 F.3d 898, 902 (8th Cir. 2003), the Eighth Circuit held that "federal common law controls in this case" because "there is no ERISA section that discusses the availability of rescission by an insurer in response to misrepresentations in a health insurance application." *Shipley*, 333 F.3d at 902. At that point, *Shipley* held that federal courts should "create federal common law by adopting and applying the common law principles that further the policy considerations underlying ERISA." *Shipley*, 333 F.3d at 902.

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[30] While not cited by either the Ninth or Third Circuits, the First Circuit appears to have adopted a similar rule. According to *Mauser v. Raytheon Co. Pension Plan for Salaried Employees*, 239 F.3d 51, 57 (1st Cir. 2001):

> However, we must exercise caution in creating new common law rules for pension plans; we should only act when there is, in fact, a gap in the structure of ERISA or in the existing federal common law relating to ERISA.

Mauser, 239 F.3d 51, 57.

Similarly, in *Phoenix Mut. Life Ins. Co. v. Adams*, 30 F.3d 554, 559 (4th Cir. 1994) the Fourth Circuit noted that creation of federal common law was appropriate when ERISA preempted state laws governing a subject but failed to provide its own requirements:

> Cases arise in which state laws are preempted because they "relate to" employee benefit plans and because they do not "regulate" the insurance industry. In those cases, if ERISA does not provide any guidance on the issue before the court, the court may be in a position to create or apply federal common law. Congress intended that the courts would develop a federal common law of rights and obligations under ERISA-regulated plans.

Phoenix Mut., 30 F.3d at 559 (citation and attribution omitted).

The Sixth Circuit also follows this view of the federal courts' power to create common law. In *Whitworth Bros. Storage Co. v. Central States Southeast & Southwest Areas Pension Fund*, 982 F.2d 1006 (6th Cir. 1993) it specifically noted the conflict between the Sixth and Third Circuits on this issue:

> In *Van Orman v. American Ins. Co.*, 680 F.2d 301 (3rd Cir. 1982), the Third Circuit stated that it was reluctant to fashion a federal common law cause of action under a doctrine of unjust enrichment for overpayments or mistaken contributions when "such a right would override a contractual provision." Id.

> at 312. This opinion is in conflict with this court's opinion in *Whitworth I*, which states that there is such a federal common law cause of action.

Whitworth Bros., 982 F.2d at 1014, n. 10.[31]

The division among the circuits as to the proper standard for creating or incorporating federal common law to regulate ERISA provides an additional rationale for this Court's review of the Ninth Circuit's decision.

III. The Ninth Circuit Erred in Refusing to Incorporate the California Notice Requirement, and Announcing a Blanket Non-Disclosure Rule Creating a Split Within the Circuits

A. The Ninth Circuit's Blanket Non-Disclosure Rule Was in Error and Creates a Split in the Circuits

The Ninth Circuit justified its refusal to incorporate the California notice requirement by pointing to a supposed rule in four other circuits that plan participants have constructive notice, as a matter of

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[31] The *Van Orman* Court also erred in suggesting that the terms of the plan should in some way limit a court's ability to fashion rules governing ERISA plans. In *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 375 (1999) this Court flatly rejected a similar argument. "UNUM's 'contra plan term' argument overlooks controlling precedent and makes scant sense."

law, of the SPD's contents. The Ninth Circuit appears to hold that courts may never require a plan to separately inform participants of anything previously disclosed in the SPD.

This is not correct. The proper standard, followed by numerous other circuits, is that an ERISA administrator's fiduciary obligations require it to separately disclose information previously communicated in the SPD, under circumstances similar to those existing here.

The Ninth Circuit's rationale in not requiring separate notification of information already contained in the SPD was as follows:

> At least four circuits have held that plan participants who have been provided with an SPD are charged with constructive knowledge of the contents of the document. *Clark v. NBD Bank, N.A.*, 3 Fed.Appx. 500, 504-05 (6th Cir. 2001) (*per curiam*) (unpublished table decision); *Barnes v. Lacy*, 927 F.2d 539, 543 (11th Cir. 1991); *Schultz v. Metro. Life Ins. Co.*, 872 F.2d 676, 680 (5th Cir. 1989); *Castello v. Gamache*, 593 F.2d 358, 360-61 (8th Cir. 1979) (*per curiam*). The Fifth and Eighth Circuits specifically declined to require plan administrators to inform participants separately of provisions already contained in the SPD.

Pet. App. 19.

This supposed non-disclosure rule does not exist. Three of the four cases listed, *Clark*, *Barnes*, and

Schultz are heavily dependent on their somewhat unusual facts and do not purport to establish a blanket rule that disclosure in the SPD will – in all circumstances – always be sufficient to notify the participant of plan terms. Nothing in these cases would conflict with the incorporation of the California notice rule.

Only the Eighth Circuit case has language which arguably supports the Ninth Circuit's bar to requiring separate disclosure of information contained in the SPD.

> However, as stated in *Wells* [*Wells v. Wilbur B. Driver Co.*, 121 N.J.Super. 185, 296 A.2d 352 (1972)], an insured is presumed to have constructive knowledge of the terms of a group policy. 296 A.2d at 358. Absent some direct command in the language of the trust agreement the Court will not imply a requirement that the trustees provide employees with that knowledge.

Castello, 593 F.2d at 361. *Castello*, however, was distinguished by a later Eighth Circuit decision holding that in some circumstances inclusion in the SPD may not fulfill the plan's disclosure obligation. *Brown v. Aventis Pharmaceuticals, Inc.*, 341 F.3d 822, 827 (8th Cir. 2003) ("Putting important information in a SPD may fulfill a company's duty to inform its employees, but it does not meet this burden when an employee does not have meaningful access to that document").

Further, the Ninth Circuit's non-disclosure rule runs counter to the D.C. Circuit's *Eddy v. Colonial Life Ins. Co. of America*, 919 F.2d 747, 287 (D.C. Cir. 1990). There Eddy was suffering from AIDS when his employer canceled his health insurance. Eddy contacted the plan fiduciary, who failed to inform him of the right to convert the group coverage to an individual policy.

The Court noted that the plan was obligated to disclose this information in the SPD. *Eddy*, 919 F.2d at 750. However, the *Eddy* Court held this was insufficient to fulfill the plan's fiduciary obligations:

> A fiduciary's duty, however, is not discharged simply by the issuance and dissemination of these documents and notices. Instead, that duty carries through in all of the fiduciary's dealings with beneficiaries; in general, a fiduciary may not materially mislead those to whom the duties of loyalty and prudence are owed. A fiduciary has a duty not only to inform a beneficiary of new and relevant information as it arises, but *also to advise him of circumstances that threaten interests relevant to the relationship.*

Eddy, 919 F.2d at 750 (citations and attributions omitted, emphasis added).

Similarly, in *Krohn v. Huron Memorial Hosp.*, 173 F.3d 542 (6th Cir. 1999) the Court found that the employer had breached its fiduciary obligations to plaintiff by failing, in response to her husband's inquiry about a related subject, to inform her of the

availability of disability benefits. This was in spite of the fact that the employer "had already informed plaintiff of the availability of long-term disability benefits by providing her with a summary plan description and an employee handbook four years earlier." *Krohn*, 173 F.3d at 548.[32] *Also Beddall v. State Street Bank and Trust Co.*, 137 F.3d 12, 22 (1st Cir. 1998) ("the obligations of an ERISA fiduciary, while governed by federal law, are informed by the common law of trusts. That law generally treats the communication of material facts to the beneficiary as the core of a fiduciary's responsibility."); *Anweiler v. American Elec. Power Service Corp.*, 3 F.3d 986, 991 (7th Cir. 1993) (duty to communicate material information "exists when a beneficiary asks fiduciaries for information, and even when he or she does not").

Here, Met Life was acting as a plan fiduciary, with a "higher-than-marketplace" obligation that it act "'solely in the interests of the participants and beneficiaries' of the plan." *Metropolitan Life Ins. Co. v. Glenn*, 128 S.Ct. 2343, 2350 (2008) (quoting from 29 U.S.C. § 1104(a)(1)). Met Life had denied Scharff's claim, denied her appeal, and notified her of her right to sue. It should have been clear to Met Life that the shortened time period to file a lawsuit was a circumstance that threatened Scharff's fundamental rights under ERISA. Also, the plan document was one

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[32] Interestingly, this case is from the Sixth Circuit, which the Ninth Circuit claims supports its rule of "constructive knowledge of the contents of" the SPD.

that two separate federal judges, Judge Bury in *Solien* and Judge Pregerson in dissent here, had found confusing.

After it denied her appeal, Met Life knew that Scharff's only remaining recourse was a lawsuit. Met Life also knew that the plan contained a time period for bringing this lawsuit that was substantially shorter than normally provided by law. Further, Met Life also knew that Ms. Scharff's claim was psychiatrically based, and that she might not be fully functioning. As such, this was clearly a situation that threatened Scharff's interest in her benefits, and the Ninth Circuit erred in not recognizing Met Life's disclosure obligation.

B. The Ninth Circuit Erred in Failing to Incorporate the California Notice Provision

The Ninth Circuit erred in not incorporating the California notice requirement into federal common law. It passes the test for incorporation set down by this Court and the lower courts in that, first, "the federal statute does not expressly address the issue before the court." *Nachwalter v. Christie*, 805 F.2d 956, 959-960 (11th Cir. 1986). Moreover, the California rule is consistent with ERISA's policies, in that it provides "employees enhanced protection for their benefits," while not overly increasing the costs or burdening the administration of welfare benefit plans. *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

The protection for employees provided by the California rule is clearly needed. Due to ERISA's lack of regulation regarding the substantive content of welfare plans, plan sponsors are free to create plans with absurdly short limitations period. For example, in *Northlake Regional Medical Center v. Waffle House System Employee Benefit Plan*, 160 F.3d 1301 (11th Cir. 1998) the Court upheld a limitations period of only 90 days. "An ERISA plan is nothing more than a contract, in which parties as a general rule are free to include whatever limitations they desire." *Northlake*, 160 F.3d at 1303.

Other plans contain accrual periods which begin running before the beneficiary has the legal right to bring a lawsuit. For example, in *Price v. Provident Life and Acc. Ins. Co.*, 2 F.3d 986 (9th Cir. 1993), the plan provided for a limitations period which began to run at the time the claim was finalized. Due to the unusual circumstances of the case, the plaintiff was unaware that benefits had been denied until the contractual accrual period had run. *Price*, 2 F.3d at 988. Fortunately, the Court overturned the district court's judgment against the insured, holding that the accrual of the claim was an issue of federal law, not contract. *Price*, 2 F.3d at 988. However, the absurd result of a limitations period running before the claimant even knew the claim had been denied would have been upheld in at least five circuits. *Burke v. PriceWaterHouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 81 (2nd Cir. 2009) ("We join the Fifth, Sixth, Seventh, and Eighth Circuits in

upholding written plan terms including limitations periods which may begin to run before a claimant can bring legal action.").

ERISA guarantees employees a federal forum to challenge benefit denials. Unusually short limitations periods or accrual periods running prior to the right to sue undoubtedly cause many of the persons ERISA was enacted to protect to lose that right. Incorporating the California notice rule and requiring that notice of the limitations period be separately provided at the time of the final denial would ensure that employees at least know the time period in which they must act before their legal rights are permanently impaired.

Moreover, the California notice rule would have minimal impact on plan creation as it would not limit what the parties may agree to in the plan documents. As noted in *White v. Sun Life Assur. Co. of Canada*, 488 F.3d 240, 250 (4th Cir. 2007), there may be legitimate reasons for a reduced limitations period. The California notice provision would not interfere with the plan sponsor's freedom to incorporate such provisions into the plan. The only requirement is that, if the plan fiduciary wishes the limitations period to be enforceable, it must be disclosed in the denial or uphold letter.

Minimal burden on plan administration is also present, as the California rule has been imposed on insurance funded ERISA plans for years. There is no evidence that compliance with the provision is

burdensome, or causes any disruption in the administration of these insured plans.

Also, creation of Federal common law is effectively accomplished by "look[ing] to state law as a model because of the states' greater experience in interpreting insurance contracts and resolving coverage disputes." *Horton v. Reliance Standard Life Ins. Co.*, 141 F.3d 1038, 1041 (11th Cir. 1998). Numerous Courts agree that "[s]tate common law may be used as a basis in constructing a federal common law that implements the policies underlying ERISA where it is not inconsistent with congressional policy concerns." *Trustmark Life Ins. Co. v. University of Chicago Hospitals*, 207 F.3d 876, 881 (7th Cir. 2000). *Also*, *Lincoln Mills*, 353 U.S. at 457 ("state law, if compatible with the purpose of s 301, may be resorted to in order to find the rule that will best effectuate the federal policy").

CONCLUSION

Because this case presents important issues of federal law on which the circuits are divided and which have not been, but should be, settled by this Court, Ms. Scharff respectfully requests that her petition for certiorari be granted.

Respectfully submitted,

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581 F.3d 899

United States Court of Appeals,
Ninth Circuit.

Donna **SCHARFF**, Plaintiff-Appellant,

v.

RAYTHEON COMPANY SHORT TERM DISABILITY PLAN; Raytheon Company Long Term Disability Plan, Defendants-Appellees.

No. 07-55951.

Argued and Submitted Feb. 4, 2009.
Filed Sept. 9, 2009.

Peter S. Sessions and Lisa S. Kantor, Kantor & Kantor LLP, Northridge, CA, for the plaintiff-appellant.

Ariadne Staples, Metropolitan Life Insurance Company, Long Island City, NY; and Robert K. Renner, Barger & Wolen LLP, Irvine, CA, for the defendants-appellees.

Appeal from the United States District Court
for the Central District of California,
Philip S. Gutierrez, District Judge, Presiding.
D.C. No. CV-07-00134-PSG.

Before: HARRY PREGERSON, SUSAN P. GRABER, and KIM McLANE WARDLAW, Circuit Judges.

Opinion by Judge GRABER; Dissent by Judge PREGERSON.

GRABER, Circuit Judge:

Plaintiff Donna Scharff worked for the Raytheon Company. The Raytheon Company employees' contributions, which are held in the Raytheon Employees Disability Trust ("Trust"), and the Company jointly fund Defendant Raytheon Company Short Term Disability Plan ("Short Term Plan"). Only the Trust funds Defendant Raytheon Company Long Term Disability Plan ("Long Term Plan"). Metropolitan Life Insurance Company ("MetLife") administers, but does not insure, the Plans. The Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 ("ERISA"), governs both Plans.

The Plans contained a contractual one-year statute of limitations. After MetLife denied her claim for Short Term Plan benefits, Plaintiff brought suit in federal court seeking benefits under both Plans, but she filed the action twenty days after the one-year contractual statute of limitations had lapsed. The district court dismissed the action as untimely. We hold that even if the doctrine of "reasonable expectations" applied here, the one-year statute of limitations met its requirements and also met the statutory and regulatory standards for disclosure. We decline to import into federal common law a California regulation requiring insurers to inform claimants expressly of statutes of limitations that may bar their claims. Accordingly, we affirm the judgment dismissing the action.

FACTUAL AND PROCEDURAL HISTORY

When Plaintiff applied for short-term disability benefits, she was an employee of the Raytheon Company and a participant in the Raytheon Company's employee benefit plans. As noted above, both the Short Term and Long Term Plans were self-funded. MetLife administers the plans and has sole discretionary authority to determine a participant's eligibility for benefits.

Raytheon provided Plaintiff and other plan participants with a Summary Plan Description ("SPD") called "Your 2005 Benefits Handbook." The SPD is divided into chapters that address the different benefits available to Raytheon employees. The final chapter of the document is entitled "**Administrative**" and provides participants with information relating to their rights and obligations under all of the benefit plans discussed in earlier chapters. The Administrative chapter contains a section titled "**Your Right to Appeal a Denied Claim,**" which explains the procedure for appealing a denied claim to MetLife. On the same page, a large-typeface, bolded heading, "**Special Rules for Disability and Health Claims,**" introduces a paragraph that cautions: "With respect to disability and health plans . . . time limits for deciding and appealing claims are significantly different from those for[other] claims. . . ." Later in the Administrative chapter is a section titled "**Your Rights under ERISA.**" A subsection, titled "**Enforce Your Rights,**" states: "If you have a claim

for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court."

The "**Disability**" chapter, which contains information about the Plan under which Plaintiff sought benefits, sets forth the deadline for bringing a lawsuit regarding a denied claim. The last page of this chapter contains a paragraph with the large-typeface, bolded, and italicized heading, "**Claims Appeal Procedure.**" That paragraph states:

> The procedure to be followed to appeal a denied claim is explained in the *Administrative* section. It is important to note that under the applicable [Plan] documents, any action at law or in equity must be commenced within one year of the denial of the appeal from an initial claim denial, regardless of any state or federal statutes establishing provisions relating to limitations of actions.

On April 15, 2005, MetLife received a claim from Plaintiff for Short Term Plan benefits. The claim was denied in a letter dated July 18, 2005, on the ground that the clinical reports did not show that Plaintiff had a condition that would render her totally disabled and unable to work. The letter described the MetLife process for appealing the denial. Plaintiff submitted additional medical information without formally appealing the denial. MetLife reviewed the information and issued a second denial letter on September 16, 2005. Plaintiff formally appealed that denial on October 28, 2005.

On January 12, 2006, MetLife issued a decision upholding its previous determination. That letter provided, in relevant part, that "[t]his determination is the final decision on review and constitutes completion of the full and fair review required by the [Short Term] Plan and federal law." The letter informed Plaintiff that if she wished to pursue the matter further, "[she] should consult the information provided concerning [her] rights, as set forth in the [SPD]." The letter went on to explain that no further administrative appeals were available concerning Plaintiff's claim for disability benefits, but that she had a "right to bring a civil action under Section 502(a) of [ERISA]." MetLife also promised to provide Plaintiff with copies of the documents relevant to her claim upon her request. None of the letters mentioned the contractual one-year statute of limitations.

Following receipt of the final denial letter, Plaintiff's daughter and personal representative, Jessica Leighty, filed a complaint with the California Department of Insurance on Plaintiff's behalf. On June 14, 2006, MetLife responded to the Department, informing it that, because the Plan is not funded through an insurance policy, it is not subject to state laws governing insurers. MetLife also wrote to Ms. Leighty to explain how it had administered Plaintiff's claim. That letter reminded her that "denial of the claim was upheld on January 12, 2006."

Under the one-year statute of limitations contained in the SPD, the deadline to file suit was January 12, 2007. Plaintiff filed suit on February 1,

2007, twenty days after expiration of the limitations period. In her complaint, Plaintiff alleged that MetLife upheld its prior determination denying benefits in its June 14, 2006, letter to her daughter, rather than in its January 12, 2006, letter. Defendants moved to dismiss under Federal Rule of Civil Procedure 12(b)(6), on the ground that the complaint was untimely. In her response, Plaintiff conceded that the statute of limitations ran on January 12, 2007, and that her complaint was untimely. She later conceded that the one-year limitation was reasonable, and she did not assert that the wording of the one-year limitations period was unclear. She argued, however, that her late filing should be excused because the limitations provision was placed neither in what she believed was the appropriate section of the SPD nor in the correspondence that she received from MetLife.

The district court first addressed whether an insurer may shorten the limitations period for bringing an ERISA suit and whether the contractual limitations period is enforceable, issues that Plaintiff does not raise on appeal and that we therefore do not consider. The court then declined to use the reasonable expectations doctrine to find that the limitations period was not displayed conspicuously enough, holding that the reasonable expectations rule has not been extended to self-funded benefits plans. The court also declined to apply section 2695.4(a) of title 10 of the California Code of Regulations, which provides that an insurer must disclose to a claimant

any time limits that may apply to the claim. The court noted that state insurance regulation of self-funded plans, like the Plan at issue here, is preempted, and the California regulation has not been incorporated into federal common law. Plaintiff timely appeals.

STANDARD OF REVIEW

We have jurisdiction under 28 U.S.C. § 1291. We review de novo an order granting a motion to dismiss for failure to state a claim pursuant to Federal Rule of Civil Procedure 12(b)(6). *Madison v. Graham,* 316 F.3d 867, 869 (9th Cir.2002). We must take all allegations of material fact in the complaint as true and must construe the facts in the light most favorable to Plaintiff. *Id.*

DISCUSSION

A. *Disclosure of the One-Year Deadline*

Plaintiff first argues that we should adopt the reasonable expectations doctrine to analyze the SPD and that we should hold that the placement and display of the deadline in this case violated participants' reasonable expectations. Defendants argue, in response, that the doctrine of reasonable expectations does not apply to self-funded welfare benefit plans. For the reasons explained below, we need not decide whether the reasonable expectations doctrine applies to self-funded welfare benefit plans.

ERISA's central policy goal is to protect benefit plan participants "by requiring the disclosure and reporting to participants and beneficiaries of financial and other information . . . and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b); *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026, 1035 (9th Cir.2006). To further that goal, employee benefit plans must provide plan participants with an SPD, which is the "statutorily established means of informing participants of the terms of the plan and its benefits," and which serves as "the employee's primary source of information regarding employment benefits." *Bergt v. Ret. Plan for Pilots Employed by MarkAir, Inc.*, 293 F.3d 1139, 1143 (9th Cir.2002) (internal quotation marks omitted); 29 U.S.C. § 1022(a).

Section 1022(a) provides in pertinent part:

> The [SPD] shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.

Section 1022(b) lists the specific information that the SPD is required to contain. One of the required pieces of information is any "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits." 29 U.S.C. § 1022(b). Accordingly, the

SPD must explain the "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits" in a manner "calculated to be understood by the average plan participant," and that information must be "sufficiently accurate and comprehensive to reasonably apprise" plan participants of their rights and obligations under the plan. *Id.* § 1022(a) & (b).

The Federal Regulations further provide:

> Any description of exception, limitations, reductions, and other restrictions of plan benefits shall not be minimized, rendered obscure or otherwise made to appear unimportant. Such exceptions, limitations, reductions, or restrictions of plan benefits shall be described or summarized in a manner not less prominent than the style, captions, printing type, and prominence used to describe or summarize plan benefits.

29 C.F.R. § 2520.102-2(b). The SPD must also disclose limitations in close conjunction to benefits provisions, or refer the participant to the page numbers on which the relevant restrictions appear. *Id.*

Those are the relevant statutory and regulatory disclosure provisions relating to the SPD. In addition to those requirements, the federal courts have developed a body of ERISA federal common law. *See Menhorn v. Firestone Tire & Rubber Co.,* 738 F.2d 1496, 1500 (9th Cir.1984) ("The courts are directed to formulate a nationally uniform federal common law to supplement the explicit provisions and general

policies set out in ERISA, referring to and guided by principles of state law when appropriate, but governed by the federal policies at issue.").

It is one of those common law principles, the doctrine of reasonable expectations, that Plaintiff asks us to use to analyze the display and placement of the one-year deadline in this case. The doctrine can be summarized as follows:

> Under the so-called "doctrine of reasonable expectations," which is often applied in interpreting or construing policies of insurance, the meaning of an insurance policy is determined in accordance with the reasonable expectations of the insured. In other words, the meaning of the terms in an insurance policy is to be determined by considering it in light of whether a reasonable person in the position of the insured would expect coverage. The term "insured's reasonable expectations" refers to what a hypothetical reasonable insured would glean from the wording of the particular policy and kind of insurance at issue, rather than how a particular insured who happened to buy the policy might understand it.

16 Samuel Williston & Richard A. Lord, *A Treatise on the Law of Contracts* § 49:20, at 111-12 (4th ed.2000) (footnotes omitted). Plaintiff argues that the placement and display of the deadline failed to meet plan participants' reasonable expectations because (1) the deadline should have been placed in the Administrative chapter rather than the Disability

chapter, and (2) the deadline should have been displayed more conspicuously in the text of the SPD.

Plaintiff is correct in asserting that we have incorporated the reasonable expectations doctrine into ERISA federal common law when we have interpreted insured plans. In *Saltarelli v. Bob Baker Group Medical Trust,* 35 F.3d 382, 387 (9th Cir.1994), we "adopt[ed] the doctrine of reasonable expectations as a principle of the uniform federal common law informing interpretation of ERISA-governed insurance contracts." At issue in *Saltarelli* was a pre-existing conditions exclusion that appeared in the SPD. *Id.* at 385. We noted that the plan administrator "chose to bury one of the plan's most significant provisions amidst definitions, rather than forthrightly stating the pre-existing conditions exclusion in the operative clauses of the plan description." *Id.* We therefore held that the exclusion for pre-existing conditions "was not clear, plain, and conspicuous enough to negate layman Saltarelli's objectively reasonable expectations of coverage." *Id.* at 387.

We noted that the application of the reasonable expectations doctrine to ERISA insurance contract law was, at the time, an issue of first impression for our circuit. *Id.* at 386. We gave two reasons for adopting the doctrine into the federal common law: (1) "protecting the reasonable expectations of insureds appropriately serves the federal policies underlying ERISA," and (2) "at least thirty states ha[d] explicitly incorporated . . . the reasonable expectations doctrine

into their own law, . . . demonstrat[ing] its widespread acceptance and vitality." *Id.* at 386-87.

After *Saltarelli,* we assumed, in dictum, that the reasonable expectations doctrine applied to a self-funded benefit plan. In *Winters v. Costco Wholesale Corp.,* 49 F.3d 550 (9th Cir.1995), the plaintiff sought reimbursement from a self-funded benefit plan for a procedure similar to in vitro fertilization. The district court held that the plan administrator should not have denied benefits. *Id.* at 552. The administrator argued that the district court (1) applied the wrong standard of review to its decision and (2) improperly applied the doctrine of *contra proferentem,* under which ambiguities in a contract are construed against the contract's drafter. *Id.* at 553. After addressing those two issues, we discussed the holding of *Saltarelli. Id.* at 554-55. We then concluded – even though the plaintiff had not argued that the reasonable expectations doctrine applied to her case – that she had "no objectively reasonable expectation of coverage" for her procedure because the SPD conspicuously exempted those types of procedures. *Id.* at 555.

We hemmed in the doctrine just two years after *Winters.* In *Estate of Shockley v. Alyeska Pipeline Service Co.,* 130 F.3d 403, 407 (9th Cir.1997), we declined to extend *Saltarelli*'s rule to an ERISA pension plan. We held that the doctrine of reasonable expectations applies *only* to "insurance contracts, including ERISA insurance contracts." *Id.* We noted that the doctrine "'grew out of the law of adhesion

contracts and construction of ambiguities in insurance policies,'" *id.* (quoting *Saltarelli,* 35 F.3d at 386), so it made sense to apply the "body of law dealing generally with insurance policy interpretation" to "insurance policies that happened to be ERISA insurance policies." *Id.* In our view, there was "no reason to extend the doctrine beyond insurance contracts" because "[the doctrine] was developed for and applies directly to insurance policies." *Id.*

Self-funded benefit plans like Raytheon's are not insurance policies. As a result, *Estate of Shockley* would appear to bar application of the doctrine of reasonable expectations to the plan at issue here. But, at the same time, *Winters* could be read to have extended the doctrine implicitly to apply to self-funded ERISA welfare benefit plans. *Estate of Shockley* mistakenly cites *Winters* as an example of an ERISA insurance contract. *Estate of Shockley,* 130 F.3d at 407 (citing *Winters,* 49 F.3d at 554-55).

What we have, then, are two opinions that are seemingly in tension with one another: *Winters,* which applied the reasonable expectations doctrine to a self-funded plan, at least in dictum, and *Estate of Shockley,* which prohibits us from expanding the doctrine beyond insured plans. As a three-judge panel, we cannot overrule either decision. *Ross Island Sand & Gravel Co. v. Matson (In re Complaint of Ross Island Sand & Gravel),* 226 F.3d 1015, 1018 (9th Cir.2000) (per curiam).

But we need not call for en banc consideration, nor try to harmonize the apparent conflict in our precedents. Assuming, without deciding, that the reasonable expectations doctrine applies, the SPD here met plan participants' reasonable expectations, in addition to fulfilling the statutory and regulatory requirements. *See Estate of Shockley,* 130 F.3d at 407 (treating the statutory disclosure requirements and the common law reasonable expectations doctrine as different inquiries). It is the statutory and regulatory requirements to which we turn next. Our task is to determine whether the deadline was "written in a manner calculated to be understood by the average plan participant" and whether it was "sufficiently accurate and comprehensive to reasonably apprise" participants of their rights and obligations under the plan. 29 U.S.C. § 1022(a). We must also ensure that the deadline was not minimized or otherwise obscured and that the limitations provision was placed near the benefits provisions. 29 C.F.R. § 2520.102-2(b).

Preliminarily, we note that a statute of limitations for bringing suit qualifies as a circumstance "which may result in disqualification, ineligibility, or denial or loss of benefits." 29 U.S.C. § 1022(b); *see Dodson v. Woodmen of World Life Ins. Soc'y,* 109 F.3d 436, 439 (8th Cir.1997) (noting that the omission from the SPD of a time limit for filing suit violated § 1022(b) because the time limit was a circumstance that might result in loss of benefits). Therefore, the

placement and display of the deadline must meet the statutory and regulatory standards.

We hold that the manner of disclosure in this case met those standards. First, placement of the deadline in the Disability chapter, rather than in the Administrative chapter (where Plaintiff argues it should have appeared) was reasonable. *See Abena v. Metro. Life Ins. Co.*, 544 F.3d 880, 884 (7th Cir.2008) (holding that placement of a contractual limitations period in a section entitled "Claims" was reasonable). The correspondence that MetLife sent to Plaintiff informed her that she had a right to sue and that she could find more information about her rights in the SPD. A reasonable plan participant applying for *disability* benefits would be expected to read, in its entirety, the *Disability* chapter of the SPD, as it explains the rules relating to the benefits for which she is applying. The one-year deadline for filing suit regarding disability claims was, logically, placed at the end of the disability chapter, satisfying the nearness requirement of 29 C.F.R. § 2520.102-2(b).

Second, within the Disability chapter, the deadline was written in a manner calculated to be understood by the average plan participant and was not minimized. 29 U.S.C. § 1022(a); 29 C.F.R. § 2520.102-2(b). A reasonable plan participant whose disability claim had been denied would proceed, naturally, to examine the information that appears under the large-typeface, bolded, and italicized heading, "**Claims Appeal Procedure.**" There, the participant would find out that, if she wishes to bring

a lawsuit, she must do so within one year of MetLife's denial of the appeal of her claim. The deadline was not obscured by being placed in the middle of other terms relating to claims appeal procedure; nor was it relegated to "fine print." We believe that the average plan participant in Plaintiff's position would have located and understood the one-year deadline in the SPD.

For these reasons, we hold that the placement and display of the one-year statute of limitations met the statutory and regulatory requirements. Turning, then, to the final issue concerning the wording of the SPD, we hold that the placement and display of the one-year statute of limitations sufficed to meet plan participants' reasonable expectations, assuming that the doctrine applies.

B. *Duty to Inform*

Plaintiff next argues that the one-year limitation should not be enforced because MetLife did not inform her of the time limit in any of its correspondence to her. Plaintiff concedes that the Plan met all applicable ERISA disclosure requirements and that MetLife was not obligated under ERISA to inform her of the deadline. She argues, however, that we should impose an additional "duty to inform" on claims administrators drawn from a California insurance regulation. We decline to do so.

Plaintiff urges us to incorporate into ERISA federal common law the following California state

insurance regulation: "Every insurer shall disclose to a first party claimant or beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant." Cal.Code Regs. tit. 10, § 2695.4(a). As noted above, under ERISA's "deemer clause," state insurance regulation of self-funded plans is preempted by ERISA. *FMC v. Holliday*, 498 U.S. 52, 58, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990). Plaintiff concedes that, because the Plans here are self-funded, the California regulation cannot be applied directly, but she maintains that we should adopt the California rule into the federal common law.

In support of this position, Plaintiff cites *Mogck v. Unum Life Insurance Co. of America*, 292 F.3d 1025 (9th Cir.2002), where we stated in a footnote that we

> need not decide whether the amended California regulations[1] clarified an existing duty of the insurer to provide notice of a contractual statute of limitation, or whether a new duty to provide written notice was created, because, in any event, [the insurer's] correspondence was ineffective to trigger the policy's time limitation provision.

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[1] The California regulation is not the same regulation at issue here.

Id. at 1028 n. 1 (footnote added). Plaintiff acknowledges that *Mogck* did not actually rule on whether the insurer has a duty to inform, but asserts that the fact that we even touched upon the issue (albeit in a footnote) implies that we believe the argument is plausible. We are not persuaded. Our statement that we need not decide an issue cannot be taken as an implicit endorsement of the argument that we expressly chose not to address.

Plaintiff's argument fails for other reasons as well. As the Third Circuit has noted, "federal courts may not lightly create additional rights under the rubric of federal common law; we may exercise our common law authority to fashion new ERISA causes of action only where we deem it necessary to fill in interstitially or otherwise effectuate the statutory pattern enacted in the large by Congress." *Hooven v. Exxon Mobil Corp.*, 465 F.3d 566, 573 n. 5 (3d Cir.2006) (internal quotation marks omitted). ERISA and its implementing regulations contain broad and detailed disclosure rules to protect plan beneficiaries. *See, e.g.*, 29 U.S.C. § 1021 (providing the disclosure and reporting requirements); *id.* § 1022 (describing the disclosure requirements for the SPD); *id.* § 1132(c) (imposing penalties on plan administrators who fail to disclose required information to plan participants); 29 C.F.R. §§ 2520.104b-1 to .104b-4, .104b-10 (providing detailed regulations for reporting and disclosure). We see no need to supplement the comprehensive scheme already in place for regulating plan administrators' disclosures to participants.

We also must take into account that "Congress expects uniformity of decisions under ERISA." *Evans v. Safeco Life Ins. Co.,* 916 F.2d 1437, 1440 (9th Cir.1990) (per curiam); *see also Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 56, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987) ("The uniformity of decision which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws." (internal quotation marks omitted)). At least four circuits have held that plan participants who have been provided with an SPD are charged with constructive knowledge of the contents of the document. *Clark v. NBD Bank, N.A.,* 3 Fed.Appx. 500, 504-05 (6th Cir.2001) (per curiam) (unpublished table decision); *Barnes v. Lacy,* 927 F.2d 539, 543 (11th Cir.1991); *Schultz v. Metro. Life Ins. Co.,* 872 F.2d 676, 680 (5th Cir.1989); *Castello v. Gamache,* 593 F.2d 358, 360-61 (8th Cir.1979) (per curiam). The Fifth and Eighth Circuits specifically declined to require plan administrators to inform participants separately of provisions already contained in the SPD.

To require plan administrators within the Ninth Circuit to inform participants separately of time limits already contained in the SPD, when other circuits have rejected a similar rule, would place the Ninth Circuit out of line with current federal common law and would inject a lack of uniformity into ERISA law. Moreover, large multistate employers often issue the same welfare benefit plan to cover all their

employees, regardless of their locations. For these employers, a lack of uniformity among the circuits would be detrimental. In short, we decline to impose on plan administrators the additional requirements of California Code of Regulations title 10, section 2695.4(a), by adopting that rule into ERISA federal common law.

AFFIRMED.

PREGERSON, Circuit Judge, dissenting:

I respectfully dissent. I do not think that an average plan participant could successfully navigate through Raytheon's labyrinthine Summary Plan Description. In my view, the Summary Plan Description bounces a reader between important provisions in the *Disability* and *Administrative* chapters in a way that makes it all too easy to miss the one-year deadline for filing a claim under ERISA in federal court. First, I believe that the Summary Plan Description at issue does not meet the statutory and regulatory requirements governing employee benefit plan disclosures. Those disclosures are required to be "*written in a manner calculated to be understood by the average plan participant.*" 29 U.S.C. § 1022(a) (emphasis added). Second, even if those statutory and regulatory requirements were met, we have already applied the doctrine of reasonable expectations to self-funded ERISA plans, so I would hold that the one-year deadline here is

unenforceable because it was not set forth in a clear, plain and conspicuous statement in the plan.[1]

I.

The majority opinion holds that the placement and display of the one-year deadline meets the statutory and regulatory requirements provided by ERISA and ERISA's implementing regulations. I disagree.

A summary plan description must be "written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a). Regulations also state that:

> The format of the summary plan description must not have the effect [of] misleading, misinforming or failing to inform participants and beneficiaries. Any description of exception, limitations, reductions, and other restrictions of plan benefits shall not be minimized, rendered obscure or otherwise made to appear unimportant. Such exceptions, limitations, reductions, or restrictions of plan

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[1] We have never addressed whether a contractual provision may validly shorten the limitations period for bringing an ERISA claim, as was done here. Scharff does not object to the one-year statute of limitations on that ground, and I do not address that argument here.

> benefits shall be described or summarized in a manner not less prominent than the style, captions, printing type, and prominence used to describe or summarize plan benefits. The advantages and disadvantages of the plan shall be presented without either exaggerating the benefits or minimizing the limitations.

29 C.F.R. § 2520.102-2(b).

In concluding that the Summary Plan Description satisfies the statutory and regulatory requirements stated above, the majority opinion determines that a reasonable plan participant applying for disability benefits would be expected to read, in its entirety, the *Disability* chapter of the Summary Plan Description. Because the one-year deadline is placed within the *Disability* chapter and located at the end of that chapter, the majority opinion determines that notice of the one-year deadline was sufficient. The majority opinion also concludes that the one-year deadline is written in a manner calculated to be understood by the average plan participant. I cannot agree with the majority opinion's conclusions.

If a reasonable participant were to read the entire *Disability* chapter of the Summary Plan Description, the "Claims Appeal Procedure" subsection of the *Disability* chapter would first notify her that "[t]he procedure to be followed to appeal a denied claim is explained in the *Administrative* section." It is true that the next sentence in the *Disability* chapter's "Claims Appeal Procedure" subsection states that

"any action at law or in equity must be commenced within one year of the denial of the appeal from an initial claim denial, regardless of any state or federal statutes establishing provisions relating to limitations of actions." Even assuming that the majority opinion is correct when it states that this sentence is written in a manner calculated to be understood by the average plan participant and not minimized,[2] this sentence, which makes no mention of ERISA, is of limited use. For one thing, the reader would not yet know that she has a right under ERISA to file suit in state or federal court if her claim for benefits is denied, because that crucial piece of information can only be found in the *Administrative* chapter. In fact, the reader would not yet know the appeal procedure at all, because appeal procedures are explained later, in the *Administrative* chapter.

Once she found the *Administrative* chapter of the Summary Plan Description, there is a subsection titled "Your Right to Appeal a Denied Claim." This subsection deals with internal, administrative claims

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[2] While Scharff has not argued that the language of the plan is unclear, U.S. District Court Judge David C. Bury of the District of Arizona, reviewing this same Raytheon Summary Plan Description, noted his own difficulty in locating the one-year limitation, and further observed that "it is dubious that a lay person would understand that her limited right to file any 'action at law or in equity' referred to her right under ERISA to 'file suit in state or federal court.'" *Solien v. Raytheon Long Term Disability Plan,* No. CV 07-456, 2008 WL 2323915 at *7 (D.Ariz. 2008).

procedures and would not alert the reader to her right to file an action in federal court if her appeal is denied.[3]

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[3] In its Factual and Procedural History, the majority opinion describes the Summary Plan Description's *Administrative* chapter as including, on the same page as the "Your Right to Appeal a Denied Claim" section, a subsection with the large, bold heading "**Special Rules for Disability and Health Claims.**" This subsection states:

> With respect to disability and health plans, including claims arising under the medical, prescription drug, vision, dental, health care reimbursement account, and employee assistance plans, time limits for deciding and appealing claims are significantly different from those for claims under RAYSIP [Raytheon Savings and Investment Plan] and the insurance plan.

The majority opinion suggests that this subsection "cautions" the reader that there are different time limitations on filing suit under ERISA in federal court from the denial of a disability claim. But even the Raytheon Plan defendants acknowledge in their briefing that this "Special Rules for Disability and Health Claims" subsection of the plan has *nothing* to do with time limits on filing claims in federal court. Instead, as explained by the defendants, this subsection describes "time limits for *administrative* review of health and disability claims, as opposed to other types of welfare benefit claims" (emphasis added). A person who reads the sentence at the beginning of the subsection warning that disability claimants face "significantly different" time limits for deciding and appealing claims would not learn anything about the one-year statute of limitations on filing an ERISA claim in federal court. Later in the *Administrative* chapter is a subsection titled "Your Rights under ERISA" and within that subsection, a

(Continued on following page)

In sum, the *Administrative* chapter is the only place a plan participant would definitively learn that she has the right under ERISA to file suit in court if her claim for benefits is denied by the plan administrator. But the *Disability* section is the only place she would learn that there is a one-year statute of limitations on filing an "action at law or in equity." The plan's one-year limitation only becomes clear after a coordinated reading of the two passages, bouncing a lay reader back and forth in a way that obscures the importance of the one-year filing deadline. I would hold that this plan does not satisfy the statutory and regulatory requirements governing Summary Plan Descriptions because it is not "written in a manner calculated to be understood by the average plan participant." 29 U.S.C. § 1022(a).

II.

The majority opinion also hesitates to apply the doctrine of reasonable expectations in this case, and finds crucial the distinction between a self-funded plan (the kind of plan at issue here) and an insured plan. It concludes that our case law is unclear as to whether the doctrine of reasonable expectations can be applied to a self-funded plan. Because we have

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smaller heading that states "Enforce Your Rights." Under that smaller heading, the reader would learn that if she "ha[s] a claim of benefits that is denied or ignored in whole or in part, [she] may file suit in a state or federal court."

already applied the doctrine of reasonable expectations to a self-funded plan in *Winters v. Costco Wholesale Corp.*, 49 F.3d 550 (9th Cir.1995), I see no reason why we would not do so here.

In *Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382, 387 (9th Cir.1994), we "adopt[ed] the doctrine of reasonable expectations as a principle of the uniform federal common law informing interpretation of ERISA-governed insurance contracts." In that case, the plan administrator "chose to bury one of the plan's most significant provisions amidst definitions, rather than forthrightly stating the preexisting conditions exclusion in the operative clauses of the plan description." *Id.* at 385. We held that the district court correctly found "that the lack of a clear, plain and conspicuous statement of the exclusion" rendered the exclusion provision unenforceable. *Id.* at 386.

Later, in *Winters*, we applied the reasonable expectations doctrine in a case involving a self-funded ERISA health benefits plan, such as the plan at issue in this case. 49 F.3d at 555. In *Winters* we applied the doctrine and determined in a reasoned and thoughtful discussion that the petitioner had no reasonable expectation of coverage. *See id.* at 554-55 (describing the exclusionary clauses in the summary plan description and observing that there was "no evidence in the record upon which a reasonable trier of fact could find an objective, reasonable expectation of coverage").

Here, the plan administrators allotted Scharff one-quarter of the amount of time she would otherwise have had to file a complaint in federal court,[4] but failed to announce this drastic change in a clear, plain and conspicuous statement. The one-year deadline was buried in the confusing Summary Plan Description. Even if this plan satisfied the statutory and regulatory disclosure requirements, I would hold that the doctrine of reasonable expectations, as articulated in *Saltarelli* and *Winters,* should apply to prevent Scharff's claim from being dismissed for failure to meet the one-year statute of limitations.

III.

If one thing is clear, it's that this plan is confusing. ERISA declares that "owing to the lack of employee information and adequate safeguards concerning [the operation of employee benefit plans], it is desirable in the interests of employees and their

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[4] ERISA does not contain a statute of limitations for suits brought to recover benefits, so to determine the applicable statute of limitations, we "look to the most analogous state statute of limitations." *Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Ins. Program,* 222 F.3d 643 (9th Cir.2000) (citing *Flanagan v. Inland Empire Elec. Workers Pension Plan,* 3 F.3d 1246, 1252 (9th Cir.1993)). In California, looking to California Code of Civil Procedure § 337, the applicable statute of limitations is four years. *Wetzel,* 222 F.3d at 648. In this case, the plan administrators slashed that four-year-period to one year, and buried this pivotal change within the Summary Plan Description.

beneficiaries . . . that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans[.]" 29 U.S.C. § 1001(a). Raytheon's Summary Plan Description does not provide the required safeguards either under ERISA or under the doctrine of reasonable expectations. I respectfully dissent.

2007 WL 2947566 (C.D.Cal.)

United States District Court,
C.D. California.
Donna **SCHARFF**, Plaintiff,
v.
RAYTHEON COMPANY SHORT TERM DISABILITY PLAN, **Raytheon** Company Long Term Disability Plan, Defendants.
No. EDCV 07-134 PSG(OPx).

June 22, 2007.

Barger & Wolen LLP, Robert K. Renner, Jenny H. Wang, for Defendants Raytheon Company Short Term Disability Plan and Raytheon Company Long Term Disability Plan.

JUDGMENT

PHILIP S. GUTIERREZ, United States District Judge.

The motion of Defendants Raytheon Company Short Term Disability Plan and Raytheon Company Long Term Disability Plan (collectively "Defendants") to dismiss with prejudice the Complaint of Plaintiff Donna Scharff ("Scharff") pursuant to Federal Rule of Civil Procedure 12(b)(6) came on regularly for hearing before this Court on June 11, 2007, the Honorable Philip S. Gutierrez, District Judge presiding. Appearances of counsel were noted in the record.

After considering the moving, opposition and reply papers, as well as the arguments of counsel and all other matters presented to the Court, and for good

cause appearing, this Court rules that Scharff 's Complaint fails to state a claim upon which relief can be granted and that the Complaint should, therefore, be dismissed with prejudice. A true and correct copy of the Court's Civil Minute Order reflecting the foregoing is attached hereto and incorporated by reference. Defendants are accordingly entitled to Judgment as a matter of law in this case.

IT IS SO ORDERED, ADJUDGED AND DECREED:

1. That Judgment shall be entered forthwith in favor of Defendants and against Scharff; and

2. That Scharff shall take nothing by way of her Complaint.

Order Granting Defendant's Motion to Dismiss Plaintiff's Complaint

I. *BACKGROUND*

This action concerns Plaintiff Donna Scharff 's ("Scharff ") claims for disability benefits and is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* During the relevant time period, Scharff, a former employee of Raytheon Company ("Raytheon"), was eligible for benefits under Raytheon's short-term ("STD") and long-term ("LTD") disability benefits plans. The STD and LTD Plans are funded by contributions from Raytheon and plan participants, and are administered by Metropolitan Life Insurance Company ("MetLife").

A. *The Summary Plan Description*

Raytheon's Summary Plan Description ("SPD") contains a 13-page section entitled "Disability," which explains the STD and LTD coverage provided:

> Short-Term disability (STD) coverage provides income replacement for up to 10 weeks if you become disabled . . . You are considered *disabled* if due to a non-work related illness or injury, you are:
>
> • Under the regular care and attendance of a doctor; and
>
> • Unable to perform all the essential elements of your regular job with reasonable accommodation.
>
> . . .
>
> Long-term disability coverage provides you with benefits when an illness or injury keeps you out of work for more than the 10-week STD period.
>
> As with our STD Plan, you must be under the regular care and attendance of a doctor while you are disabled to be eligible for LTD benefits . . .
>
> For purposes of the LTD Plan, you are considered disabled for the first 15 months you are receiving LTD benefits if you are unable to perform the essential elements of your regular job with reasonable accommodation. . . .

(Anderson Dec. Ex. 1 at 0043, 0047).

The Disability section also contains a paragraph, "Claims Appeals Procedure," which states:

> . . . It is important to note that under the applicable STD, LTD and occupational LTD plan documents, any action at law or in equity must be commenced within one year of the denial of the appeal from an initial claim denial, regardless of any state or federal statute establishing provisions relating to limitations of actions.

(*Id.* at 0052).

B. *Scharff's Disability Claim*

On April 15, 2005, Scharff made a telephonic claim for disability benefits based on acute stress. (Anderson Dec. Ex. 2 at 0366). By letter dated July 18, 2005, MetLife denied Scharff's claim on the grounds that her depression and anxiety did not render her totally disabled and unable to perform the essential elements of her job. (*Id.* at 0367). Scharff subsequently submitted a note dated August 31, 2005 from her physician indicating that she was tearful, depressed, and needed an increase in medications to be able to cope and function. (*Id.*, Ex. 3 at 0375). On September 16, 2005, MetLife again denied Scharff's claim. (Complaint, ¶ 7). Scharff appealed in October 2005, but MetLife upheld the denial of STD benefits on January 12, 2006. (Anderson Dec, Ex. 4). The letter recited the reasons for MetLife's denial, and also stated:

> We have completed the full and fair review of your claim for Short-Term Disability (STD) benefits. For the reasons noted below, it is our determination the original disallowance was proper and we therefore, must uphold the disallowance of your Short-Term Disability benefits . . .
>
> This determination is the final decision on review and constitutes completion of the full and fair review required by the Plan and federal law.
>
> Should you wish to pursue the matter further you should consult the information provided concerning your rights, as set forth in the Summary Plan Description ("SPD") . . .
>
> You also have the right to bring a civil action under Section 502(a) the Employee Retirement Income Social Security Act of 1974 ("ERISA").
>
> Please be advised that under the provision of the Plan, no further administrative appeals are available concerning your disability benefits.

(*Id.* 0590, 0592).

On May 25, 2006, Jessica Leighty filed a complaint on behalf of Scharff with the California Department of Insurance ("CDI"). (*Id.* at Ex. 5). The CDI contacted MetLife, who responded that the because the STD Plan is not funded by an insurance policy but rather is self-funded employee welfare benefits

plan, then the STD Plan is not subject to state laws and regulations governing insurers and insurance policies. (*Id.*). MetLife included in its response a copy of the letter to Leighty, dated June 14, 2004, which contained much of the same information as the January 12, 2006 letter, discussing why MetLife denied Scharff's claim. (*Id.* at 0566-0568). The letter also explained that in order to be eligible for LTD benefits, a claimant must first receive the full 10-week period of STD benefits. (*Id.* at 0567). Finally, the letter informed Leighty:

> Please be advised that under the terms and conditions of the Plan, no further administrative appeals are available to Donna Scharff concerning her disability benefits. Ms. Scharff does have the right to bring a civil action under Sections 502(a) of the Employee Retirement Income Social Security Act of 1974 ("ERISA"), if she chooses to do so.

(*Id.* at 0568).

On February 1, 2007, Scharff filed a Complaint against Defendant Raytheon Company's STD and LTD Plans. Defendant now moves to dismiss pursuant to Fed.R.Civ.P. 12(b)(6).

II. *WHETHER THE COURT MAY CONSIDER DEFENDANT'S EXHIBITS?*

As a preliminary matter, the Court addresses whether it may, on a motion to dismiss, consider five exhibits submitted by Defendant, without converting

the motion to dismiss into one for summary judgment. (*See* Anderson Dec, Exs. 1-5). For the following reasons, the Court concludes that it may.

In general, when ruling on a motion to dismiss under Fed.R.Civ.P. 12(b)(6), the court must disregard facts not alleged on the face of the complaint or contained in documents attached to the complaint. *Knieval v. ESPN,* 393 F.3d 1068, 1076 (9th Cir.2005) (citations omitted). If a defendant attaches extrinsic evidence to a Rule 12(b)(6) motion, the court ordinarily must convert that motion into one for summary judgment under Rule 56 to give the plaintiff an opportunity to respond. *Anderson v. Angelone,* 86 F.3d 932, 934 (9th Cir.1996). However, under the incorporation by reference doctrine, a court may look to materials beyond the pleadings if the contents are alleged in a complaint and neither party questions the materials authenticity. *Knieval,* 393 F.3d at 1076 (citations omitted). Furthermore, this doctrine has been extended to include situations in which the plaintiff does not explicitly allege the contents of that document in the complaint, but the defendant attaches the document to its motion to dismiss, the plaintiff's claim depends on its contents, and the parties do not dispute its authenticity. *Parrino v. FHP, Inc.,* 146 F.3d 699, 706 (9th Cir.1998). In *Parrino,* the Ninth Circuit explained the policy underlying the rule: "Preventing plaintiffs from surviving a Rule 12(b)(6) motion by deliberately omitting references to documents upon which their claims are based, *see Pension Benefit Guaranty Corp. v. White Consol.*

Indus., 998 F.2d 1192, 1196 (3d Cir.1993)." *Parrino*, 146 F.3d at 706.

Scharff alleges in her Complaint the following pertinent facts:

- On September 16, 2005, Scharff's claim for STD benefits was denied by Raytheon. (Complaint, ¶ 7).
- On October 28, 2005, Scharff appealed this determination. (*Id.*).
- On June 14, 2006, Raytheon upheld its prior determination. (*Id.*).

The exhibits attached to the Anderson Declaration provide additional pertinent facts. In fact, Exhibit 4 shows that MetLife actually denied Scharff's claim on January 12, 2006, over six months prior to the alleged appeal denial date of June 14, 2006. The five exhibits are:

Exhibit 1: Raytheon's Summary Plan Description

Exhibit 2: Letter dated July 18, 2005 from MetLife to Scharff, denying Scharff's initial claim for disability.

Exhibit 3: Letter dated September 16, 2005 from MetLife to Scharff, supplementing the previous letter of denial.

Exhibit 4: Letter dated January 12, 2006, from Metlife to Scharff, denying Scharff's appeal.

> Exhibit 5: Letter dated June 14, 2006, from Metlife to Scharff's representative Jessica Leighty, upholding its original disallowance of the claim.

Here, because Paragraph 13[1] of the Complaint refers to and quotes from the SPD, under the incorporation by reference doctrine, the Court may properly consider Exhibit 1. Additionally, even if the Complaint did not refer to the SPD, the Court could still properly consider it since the SPD document is integral to Scharff's claims, and Scharff does not dispute its authenticity.

Similarly, Exhibits 2-5, letters from MetLife to Scharff denying her disability claim and appeal, are integral to Scharff's claims for benefits in this lawsuit. Scharff does not dispute their authenticity and refers to them herself in the Opposition. (Opp'n at 3). Thus, the Court may properly consider Exhibits 2-5.

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[1] Paragraph 13 of the Complaint reads:

> As a further direct proximate result of aforementioned wrongful conduct of the STD Plan, Plaintiff has been wrongfully precluded from obtaining disability benefits to which she is due under the LTD Plan in a total sum to be shown at the time of trial as Raytheon's 2005 Benefits Handbook provides, "Because MetLife administers both the STD and LTD Plan, you are not required to submit a separate claim for LTD benefits. While you are receiving STD benefits, MetLife remains in close contact with your doctor to monitor your condition. If you continue to be disabled beyond the 10 consecutive weeks, MetLife automatically converts your STD benefits to LTD benefits.

III. *LEGAL STANDARD FOR MOTION TO DISMISS*

Rule 12(b)(6) of the Fed.R.Civ.P. provides a mechanism for a party to dismiss a claim if the claimant fails to state a claim upon which relief can be granted. In evaluating the sufficiency of a complaint under Rule 12(b)(6), courts must be mindful that the Federal Rules require only that the complaint contain "a short and plain statement of the claim showing that the pleader is entitled to relief." Fed.R.Civ.P. 8(a). Nevertheless, even though a complaint attacked by a Rule 12(b)(6) motion to dismiss does not need detailed factual allegations, "a plaintiff's obligation to provide the 'grounds' of his 'entitle[ment] to relief' requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." *Bell Atlantic Corp. v.. Twombly,* 127 S.Ct. 1955, 1965 (2007) (internal citations omitted). The complaint must allege sufficient facts to raise a right to relief above the speculative level. *See Id.* (citing 5 C. Wright & A. Miller, Federal Practice and Procedure § 1216, pp. 235-236 (3d ed.2004).

In deciding a 12(b)(6) motion, a court must accept as true all factual allegations in the complaint, *see Leatherman v. Tarrant County Narcotics Intelligence and Coordination Unit,* 507 U.S. 163, 164 (1993), and views these allegations in the light most favorable to the plaintiff. *See Warth v. Seldin,* 422 U.S. 490, 501 (1975).

IV. *DISCUSSION*

MetLife denied Scharff's appeal on January 12, 2006, and Plaintiff filed her Complaint on February 1, 2007, exactly one year and 20 days later. Defendant argues that Scharff's claims are barred by the SPD's one year limitations period, which requires a claimant to commence any action in law or equity within one year of the denial of the appeal regardless of any state or federal statute establishing provisions relating to limitations of actions. (*Id.* at 0052). Scharff concedes that ERISA plans may provide for a shorter contractual limitations period within which plan participants may bring a civil action, and that such limitations are enforceable if they are reasonable. However, Sharff makes two arguments as to why this particular contractual limitations period is unenforceable. First, Scharff contends that because MetLife failed to specify the limitation period in its denial letters, Defendant should be estopped from asserting the contractual limitations period as a defense. Second, Scharff argues the limitation period was not clear, plain or conspicuous enough to overcome her reasonable expectation that she would have more time in which to sue.

A. *Whether an Insurer May Shorten the Limitations Period for Bringing an ERISA Suit for Disability Benefits?*

Before addressing Scharff's arguments, the Court first considers whether an insurer may validly shorten the limitations period for bringing an ERISA suit

for disability benefits. ERISA does not provide a statute of limitations for suits brought under § 502(a)(1)(B) to recover benefits, so courts borrow the most closely analogous state limitations period. *Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Ins. Program,* 222 F.3d 643, 646 (9th Cir.2000). In *Wetzel,* the Ninth Circuit analogized ERISA disability claims with actions based on a written contract, and held that the four-year statute of limitations period under Cal.Code Civ. P. § 337 applied.[2] *Id.* at 648. In so holding, the Ninth Circuit overruled its previous decision that the disability policy provision found in the Cal. Insurance Code § 10350.11 provided the relevant statutory period.[3] *Id.* The Ninth Circuit explained that many courts have treated policy provisions arising out of the application of § 10350.11 as a contractual limitations periods operating distinct and apart from the statutory limitations period set by the state legislature. *Id.* Thus, although § 10350.11 performed much the same functions as would a statute of limitations, it was not itself a statute of limitations. *Id.*

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[2] Cal.Code Civ. P. § 337 provides that "[a]n action upon any contract, obligation or liability founded upon an instrument in writing" be brought within four years.

[3] Cal. Ins.Code § 10350.11 states: "No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished."

Whether a contractual provision may validly shorten the limitations period for bringing an ERISA claim has not yet been addressed by the Ninth Circuit. However in two cases, *Wetzel,* 222 F.3d at 646 and *Mogck v. Unum Life Ins. Co. of America,* 292 F.3d 1025 (9th Cir.2002), the Ninth Circuit has suggested it would allow shorter periods contained in a policy. In *Wetzel,* after determining a four-year statute of limitations period applied to ERISA claims and finding the plaintiffs claim was not barred by the four year period, the Ninth Circuit next asked "whether Wetzel's action [was] contractually barred by the limitations provision in the policy." *Wetzel,* 222 F.3d at 650. The relevant provision provided that an action to recover benefits had to be commenced "within three years after the time written proof of loss [was] required." *Id.* Ultimately, the Ninth Circuit remanded the case to the district court since the record lacked sufficient information for it to determine when proof of loss was decided. *Id* . However, the fact that the Ninth Circuit proceeded to analyze whether the contractual provision barred plaintiffs claim after deciding the four-year statute of limitations did not bar his claim, implies the Ninth Circuit believes the ERISA statutory period may be altered by the terms of the policy.

This implication is also found in *Mogck,* a case involving a similar contractual limitation which provided a claimant could not start a legal proceeding more than three years after the time proof of claim is required. *Mogck,* 292 F.3d at 1028. Just like in *Wetzel,*

the Ninth Circuit first analyzed whether the claimant was barred statutorily by the four-year ERISA period, and after determining that he was not, went on to consider whether the three-year contractual limitation barred his claim. *Id.* In reversing the district court's finding that the plaintiff's claim was barred by the three-year period, the Ninth Circuit reasoned that since the insurer never made an adequate request for proof, it never took the steps necessary to trigger the running of the contractual time limitation. *Id.*

Based on the Ninth Circuits analyses in *Wetzel* and *Mogck*, implying that an insurer may modify the ERISA four-year limitation period by the terms of the policy, the Court finds that a one-year contractual limitation period may be enforceable.

B. *Whether Defendant is Estopped From Raising the Plan's One-Year Contractual Limitations Period as a Defense?*

Citing § 2695.4(a) of the California Code of Regulations, Scharff first contends Defendant should be estopped from asserting the contractual limitation period as a defense since it failed to conspicuously disclose in any of its three denial letters the one-year limitation period. The Court is not persuaded.

Section 2695.4, which is part of the Fair Claims Settlement Practices Regulations (§§ 2695.1-2695.17) issued by the California Insurance Commissioner

(Cal. Reg. Notice Register 92, No. 52 (Dec. 15, 1992)), states:

> Every insurer shall disclose to a first party claimant or beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant. When additional benefits might reasonably be payable under an insured's policy upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer's additional liability.

10 Cal.Code Reg. § 2695.4(a).

Here, because the STD Plan is a self-funded plan and not an insured plan, § 2695.4(a) does not apply. In *FMC v. Holliday,* 498 U.S. 52, 111 S.Ct. 403 (1990), and *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 105 S.Ct. 2380 (1985), the Supreme Court recognized that ERISA treats insured plans and self-funded plans differently for preemption purposes. Thus, while state insurance regulation of insured plans is permissible, state insurance regulation of self-funded plans is preempted. *See Holliday,* 111 S.Ct. at 407-11; *Metropolitan Life,* 471 U.S. at 738-47. In explaining this conclusion, the Supreme Court cited ERISA's "deemer" clause, which makes clear that employee benefit plans may not be "deemed" insurance companies "for purposes of any law of any

State purporting to regulate insurance companies, [or] insurance contracts." 29 U.S.C. § 1144(b)(2)(B).

Scharff nevertheless urges the Court to "borrow" § 2695.4(a) and make it part of ERISA federal common law. The courts have been directed to formulate a nationally uniform federal common law to supplement the explicit provisions and general policies set out in ERISA, referring to and guided by principles of state law when appropriate, but guided by the federal policies at issue. *Menhorn v. Firestone Tire & Rubber Co.*, 738 F.2d 1496, 1500 (9th Cir.1984). Scharff argues that although the Ninth Circuit declined to decide the issue of whether California insurance laws apply to apply to ERISA fiduciaries in *Mogck*, that the Ninth Circuit even touched upon the issue, albeit in a footnote, implies it believes it should be addressed.[4] *Mogck*, 292 F.3d at 1028, Fn. 1.

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[4] In Footnote 1 of *Mogck*, the Ninth Circuit noted that subsequent to the filing of the action, California Administrative Code, Title 10 § 2695.7 was amended to add subsection (f): "Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a timely claim. . . ." *Mogck*, 292 F.3d at 1028, Fn. 1.

The Ninth Circuit, however, did not decide "whether the amended California regulations clarified an existing duty of the insurer to provide notice of a contractual statute of limitation, or whether a new duty to provide written notice was created, because, in any event, [the defendant's] correspondence was ineffective to trigger the policy's time limitation provision." *Id.*

The court's analysis in *Mogck* has no bearing on the instant case. As discussed above, *Mogck* involved a benefit plan funded by an insurance policy, whereas the STD Plan here is self-funded. *Id.* at 1026. MetLife merely acts as the claims administrator. While the Ninth Circuit, in Footnote 1, noted that "failure to give notice pursuant to California's insurance code regulations may estop an insurer from asserting a statute of limitations defense," nothing in the decision suggests the same would apply to the claims administrator of a self-funded plan. *Id.* at 1028, Fn. 1. Moreover, Scharff has cited no authority to support her assertion that Cal.Code Reg. § 2695.4(a) should apply to contractual limitation periods in self-funded ERISA policies. Accordingly, this Court declines to adopt § 2695.4(a) as part of ERISA federal common law.

C. *Whether the Contractual Limitation Period is Enforceable?*

It is a well-established rule of contract that, "in the absence of a controlling statute to the contrary, a provision in a contract may validly limit, between the parties, the time for bringing an action on such contract to a period less than that prescribed in the general statute of limitations, provided that the shorter period itself shall be a reasonable period." *Order of United Commercial Travelers v. Wolfe*, 331 U.S. 586, 608, 67 S.Ct 1355 (1947). Several courts have applied this general contract rule to claims brought under ERISA. *See, e.g., Sousa ex rel. Will of Sousa v. Unilab*

Corp. Class II (Non-Exempt) Members Group Benefit Plan, 252 F.Supp.2d 1046 (E.D.Cal.2002) ("the law allows parties to contract for a limitation period less than the standard four year statute of limitations for ERISA provided the contractual period is reasonable"); *Northlake Regional Med. Ctr. v. Waffle House Sys. Employee Benefit Plan,* 160 F.3d 1301 (11th Cir.1998) (holding that contract limitations in ERISA plans are enforceable provided they are reasonable and finding 90 day period reasonable and enforceable); *Doe v. Blue Cross & Blue Shield United of Wis.,* 112 F.3d 869 (7th Cir.1997) (upholding the plan's three year limitations period instead of state's six-year breach of contract period); *Acorn v. Raytheon Co.,* 175 F.Supp.2d 117 (D.Mass.001) (holding that a contractual limitation period of three years reasonable and enforceable); *Allen v. Unionmutual Stock Life Ins. Co.,* 989 F.Supp. 961 (S.D.Ohio 1997) (upholding three year contractual statute of limitations); *Bomis v. Metropolitan Life Ins. Co.,* 970 F.Supp. 584 (E.D.Mich.1997) (allowing three year statute of limitations for ERISA claim); 44 Am.Jur.2d Insurance 1879 (1982) (Rule that contractual limitations periods shorter than statute of limitations are permissible provided they are reasonable is applicable to ERISA plans. . . .).

Joining these other courts, this Court concludes that a shorter contractual limitation period in an ERISA governed plan should conform with the "reasonableness" standard. Application of this contract rule to limitations periods in ERISA plans makes

sense. "An ERISA plan is nothing more than a contract, in which parties as a general rule are free to include whatever limitations they desire." *Northlake Regional,* 160 F.3d 1301. And although an employer does not negotiate an ERISA plan with the individual employees, the employer still competes with other employers. *Id.* "[E]mployee benefits are an important part of the employee's total compensation package, and the creation of unreasonable barriers to obtaining the benefits may therefore hurt the employer by causing an employee backlash." *Blue Cross & Blue Shield,* 112 F.3d 869, 874-875.

Thus, in order to deem the SPD's one-year limitation period unenforceable, Scharff must show the shorter limitation period is unreasonable. Scharff, however, does not contend this. Instead, she urges the Court to apply the doctrine of reasonable expectations to the instant case, and find the contractual limitation period unenforceable because it was not clear, plain or conspicuous enough to negate Scharff's reasonable expectation that she would have more time in which to sue. Scharff relies on *Saltarelli v. Bob Baker Medical Trust,* 35 F.3d 382 (9th Cir.1994), where the Ninth Circuit adopted the doctrine of reasonable expectations in the context of an ERISA governed insurance contract.

Saltarelli involved an insured who, just days after switching insurance plans, was diagnosed with stomach cancer. *Id.* at 386-387. The new insurance plan denied liability based on a provision excluding pre-existing conditions, but the district court rejected

this argument since the attempted exclusion was not clear, plain, and conspicuous enough to negate the plaintiff's objectively reasonable expectations of coverage. *Id.* The Ninth Circuit agreed, and adopted the doctrine of reasonable expectations as a principle of the uniform federal common law informing interpretation of ERISA-governed insurance contracts. *Id.* The Ninth Circuit explained that the company was not allowed "to bury one of the plan's most significant provisions amidst definitions, rather than forthrightly stating the pre-existing conditions exclusion in the operative clauses of the plan description." *Id.* at 385.

Scharff's reliance on *Salterelli* is misplaced. First, *Saltarelli* involved an ERISA governed insurance contract, not a self-funded contract like the one in the instant case. As discussed previously, this difference is pivotal since under ERISA's deemer clause, an employee benefit plan may not be "deemed" an insurance companies "for purposes of any law of any State purporting to regulate insurance companies, [or] insurance contracts." 29 U.S.C. § 1144(b)(2)(B). Moreover, nothing in *Saltarelli* suggests the Ninth Circuit intended to extend the reasonable expectations doctrine to interpreting self-funded contracts. Finally, unlike *Salterelli's* pre-existing exclusion provision, which related to the extent of coverage afforded by the plan, the one-year contractual limitation period is a procedural provision not relating not to coverage, but to a claimant's ability to seek judicial review of a claim denial. As such, the Court rejects the application of

the reasonable expectations doctrine to the STD's one-year contractual limitations periods.

Here, the parties agree that MetLife's January 12, 2006 letter of denial constituted MetLife's final decision of Scharff's appeal. Additionally, Scharff concedes the one-year limitation period is reasonable. Thus, because Scharff filed the Complaint filed on February 1, 2007, twenty days past the SPD's one-year limitation period, Scharff's claims for STD and LTD benefits are time-barred. Accordingly, the Court grants Defendant's Motion to Dismiss.

IV. *CONCLUSION*

For the reasons set forth above, Defendant's Motion to Dismiss is hereby GRANTED, with prejudice.

IT IS SO ORDERED.

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DONNA SCHARFF, Plaintiff-Appellant, v. RAYTHEON COMPANY SHORT TERM DISABILITY PLAN et al., Defendants-Appellees.	No. 07-55951 D.C. No. CV-07-00134-PSG Central District of California, Riverside ORDER (Filed Jan. 25, 2010)

Before: PREGERSON, GRABER, and WARDLAW, Circuit Judges.

Judges Graber and Wardlaw have voted to deny the petition for panel rehearing and petition for rehearing en banc, and Judge Pregerson has voted to grant the petitions.

The full court has been advised of the petition for rehearing en banc, and no judge of the court has requested a vote on it.

The petition for panel rehearing and petition for rehearing en banc are DENIED.

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA –
WESTERN DIVISION
HONORABLE PHILIP S. GUTIERREZ,
U.S. DISTRICT JUDGE

CERTIFIED COPY

DONNA SCHARFF, PLAINTIFF, vs. RATHEON COMPANY SHORT TERM DISABILITY PLAN, ET AL., DEFENDANTS.	)	No. ED CV07-134-PSG (OPx)

REPORTER'S TRANSCRIPT OF PROCEEDINGS
LOS ANGELES, CALIFORNIA
MONDAY, JUNE 11, 2007

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* * *

[5] But we're not asking the Court to apply that to them as an insurance company. What we're doing is we're asking the Court to borrow this rule that's enunciated in the regulation and apply it to MetLife as a matter of federal common law.

Now, ERISA is, you know, famously vague when it comes to directing courts on how to interpret and apply plan provisions, and so what congress has done is said to the federal courts, "You have our blessing to create this body of federal common law to try to help yourselves out in determining how to interpret these plans." And so what we're asking the Court to do is to say, "Well, here's a regulation that applies to insurance companies, and why shouldn't it be equally held to apply to plans as well?"

THE COURT: I would be more comfortable following that argument if there was some other case that preceded me in doing that.

I mean, frankly, it seems the fair thing to do. It almost even seems the right thing to do. We're talking about 20 days, and, typically, you want claims heard on the merits. And in terms of a developing common law, I went back and looked to see if there is any case out there that has ever taken this position because I'm sure maybe not this fact pattern comes up, but there are other cases that were presented by the defense where plans have limited the time to sue. So I was curious as to – I'm sure you tried the same thing.

* * *

Effective: April 1, 2009

29 U.S.C.A. § 1022. Summary plan description

(a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

(b) The summary plan description shall contain the following information: The name and type of administration of the plan; in the case of a group health plan (as defined in section 1191b(a)(1) of this title), whether a health insurance issuer (as defined in section 1191b(b)(2) of this title) is responsible for the financing or administration (including payment of claims) of the plan and (if so) the name and address of such issuer; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and

addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan including the office at the Department of Labor through which participants and beneficiaries may seek assistance or information regarding their rights under this chapter and the Health Insurance Portability and Accountability Act of 1996 with respect to health benefits that are offered through a group health plan (as defined in section 1191b(a)(1) of this title), the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 11.33 of this title), and if the employer so elects for purposes of complying with section 1181(f)(3)(B)(i) of this title, the model notice applicable to the State in which the participants and beneficiaries reside.

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS
TITLE 10. INVESTMENT
CHAPTER 5. INSURANCE COMMISSIONER
SUBCHAPTER 7.5. UNFAIR OR DECEPTIVE ACTS OR PRACTICES IN THE BUSINESS OF INSURANCE
ARTICLE 1. FAIR CLAIMS SETTLEMENT PRACTICES REGULATIONS

This database is current through 3/26/10
Register 2010, No. 13

10 CCR § 2695.4. Representation of Policy Provisions and Benefits.

(a) Every insurer shall disclose to a first party claimant or beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant. When additional benefits might reasonably be payable under an insured's policy upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer's additional liability.

(b) No insurer shall misrepresent or conceal benefits, coverages, time limits or other provisions of the bond which may apply to the claim presented under a surety bond.

(c) No insurer shall deny a claim on the basis of the claimant's failure to exhibit property, unless there is documentation in the file (1) of reasonable demand by

the insurer, and unfounded refusal by the claimant, to exhibit property, or (2) of the breach of any policy provision providing for the exhibition of property.

(d) Except where a time limit is specified in the policy, no insurer shall require a first party claimant under a policy to give notification of a claim or proof of claim within a specified time.

(e) No insurer shall:

(1) request that a claimant sign a release that extends beyond the subject matter which gave rise to the claim payment unless, prior to execution of the release, the legal effect of the release is disclosed and fully explained by the insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature;

(2) be precluded from including in any release a provision requiring the claimant to waive the provisions of California Civil Code Section 1542 provided that, prior to execution of the release, the legal effect of the release is disclosed and fully explained by the insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature.

(f) No insurer shall issue checks or drafts in partial settlement of a loss or claim that contain or are accompanied by language releasing the insurer, the insured, or the principal on a surety bond from total liability unless the policy or bond limit has been paid, or there has been a compromise settlement agreed to by the claimant and the insurer as to coverage and amount payable under the insurance policy or bond.

(g) No insurer shall require a first party claimant or beneficiary to submit duplicative proofs of claim where coverage may exist under more than one policy issued by that insurer.

<General Materials (GM) – References, Annotations, or Tables>

Note: Authority cited: Sections 790.10, 12340-12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11152 and 11342.2, Government Code. Reference: Sections 790.03(h)(1), (3) and (4), Insurance Code.